ROCKY MOUNTAIN MEDICAL JOURNAL

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Denver 2, Colorado

Telephone AComa 2-0547

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May 1959, Volume 56, Number 5

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A medical potpourri

Compiled by Andrew M. Babey, M.D., Las Cruces, New Mexico

1. "Dietary management of atherosclerosis that is undertaken after a cerebral or coronary occlusion is likely to do little more than arrest an already advanced and most likely irreversible process." Dr. Samuel Proger, Progress in Cardiovascular Disease, Oct. 1958, page 145.

2. "The art of consultation was not simply a question of sending a patient away for a second opinion. It was the careful selection of the man who by training and temperament was the most suitable for the matter in hand. His position in the profession, his standing in his specialty, his skill, his appearance, his manner, and his gift of tongues had all to be considered." Abercrombie, G. F.: The Art of Consultation, The Fifth James McKenzie Lecture cited in General Articles and News, Brit. M. J. 2; 1349 (Nov. 29) 1958.

3. "When a consultant and a general practitioner met, no matter how distinguished the one or how obscure or diffident the other, they met on terms of absolute equality, the one to give, the other to receive, but not necessarily to adopt, the advice tendered." ibid.

4. "Often, of course, one got no help at all from a consultation. Harley Street, in his experience, was reluctant to confess itself stumped. It would be better sometimes if it did, and the exceptions are refreshing." ibid.

5. " 'No man should die of acute or obscure disease without a consultation,' Sir Clifford Allbutt had said as long ago as 1889." ibid., p. 1350.

6. "Allbutt, whose regard Sir James Mackenzie especially valued, had gone on to say—to the students at Charing Cross Hospital—'It is you touchy young men, just out of the schools, who give us the trouble—who bridle up at the suggestion of a consultation and declare that nothing more can be done.' " ibid.

7. "The family doctor really came into his own when specialist opinions differed. In this dilemma, all looked to him to find the right solution, and he must take his courage in both hands and rise to the occasion." ibid.

8. "Neomycin was more effective than chlortetracycline, sigmamycin or chloramphenicol in treating three patients with hepatic coma due to liver failure under controlled circumstances. Neomycin therapy permitted an adequate protein intake, which, with the other drugs, caused neuropyschiatric deterioration." Summerskill, W. H. J.: Hepatic Coma in Liver Failure and Gastrointestinal Hemorrhage Treated with Neomycin, Brit. M. J. 2:1325 (Nov. 29) 1958.

9. "There are four chief reasons why honest, hard-working and conscientious doctors sometimes do harm when they think to do good; they are ignorance, misdirected enthusiasm, overconfidence, and timidity." Forbes, John: Danger! Doctor's at Work, Lancet 2:1226 (Dec. 6) 1958.

10. "It has to be admitted that most doctors compare poorly with other professional men when it comes to a knowledge of such things as literature, philosophy, logic, economics, and even science." ibid.

11. "It is unfortunately true that much well-meant health propaganda today does encourage thoughts of disease and an obsession with bodily well-being. There is a danger that we may turn the British into a nation of hypochondriacs; some would say that we are already doing so." ibid, page 1227.

12. "A timid doctor can very easily manufacture neurotics and chronic invalids, and the sad thing is that his patients are often pathetically grateful for his wonderful carefulness." ibid.

EDITORIALS

Congratulations, And Criticisms!

CONGRATULATIONS ARE DUE the Colorado State Medical Society and its attorneys upon the dismissal of one of the lawsuits that had been brought by physicians associated with the United Mine Workers Welfare and Retirement Fund. An interesting account of that development is published on page 92 in the Colorado news section of this issue of the Journal.

Just a few of the 50 states—and not all the physicians in any of those few—have been carrying the brunt of medicine's recent fight to retain its American freedoms and those of its patients. It is too bad that some of the hierarchy of the American Medical Association still cannot see the light and lend the influence of their high offices to the embattled doctors of southern Colorado and certain parts of Utah, Wyoming, Pennsylvania, West Virginia, Kentucky, and southern Illinois. In the matter of lawsuits, Colorado has been carrying the battle entirely by itself the last two years. We wish the A.M.A. had lent a hand so that it could be included in our sincere congratulations to Colorado!

Also in this issue is a critique developed, after long study we feel sure, of the A.M.A.'s famous "Report of the Commission on Medical Care Plans." The latter was filed with the A.M.A. House of Delegates last December and is up for possible action at the Atlantic City annual meeting next month. One or more other states may have, within the same length of time, developed a real study of the report but at this writing we have as yet neither seen nor heard of another—so, again, congratulations to Colorado for having a study committee sufficiently alert to come up with a clear, publishable analysis of its own state medical association thinking on this highly complex and controversial subject. We noted from the minutes of the Colorado Society's House of Delegates, published in our April issue, that this critique has the official endorsement of the House of Delegates and has been transmitted to the American Medical Association officially, together with the Colorado Society's recommendation that the "Miscellaneous and Unclassified Plans" section of the Commission report be disapproved.

Lawsuits in southern Colorado and the national Commission's official report are unavoidably related in our thinking, because the United Mine Workers medical plan, currently of the tightly-closed-panel type, is very correctly listed as one of the "miscellaneous and unclassified plans" discussed by the Commission.

We agree with the Colorado committee which criticized, perhaps less severely than we would ourselves, any set of strong recommendations relating to medical plans—250 of them serving some millions of persons—based upon a "study" by four men who apparently did not interview a single patient of any of the plans!

Carcinogenesis

IN DERMATOLOGIC PARLANCE, there is a class of cutaneous dermatoses and tumors called the precanceroses. An epithelioma develops in 20 or more per cent of such conditions as Bowen's disease, the keratoses (senile, arsenical, tar, solar), leukoplakia, cutaneous horns, and in the atrophic or ulcerated skin of severe irradiation reactions. In view of the relentless trend of the latter toward cancer, someone once said that a severely irradiated area will become cancerous if the patient lives long enough.

This statement has been paraphrased, knowingly or unknowingly, by Dr. Alton Ochsner. We know he has seen no reason to relinquish his unmitigable belief that smoking begets cancer. Dr. Ochsner has recently

and widely been quoted as saying that any intemperate smoker will acquire cancer if he lives long enough.

Obviously, neither of these statements can be disproved. It is best that they should not be, for experience and statistics tend to authenticate the apparent relationship between precanceroses, an apparently carcinogenic habit, and life-destroying tumors. Approximately 30,000 new cases and 25,000 deaths from lung cancer annually attest increased prevalence of the disease. Part of the statistics, at least, depend upon greater awareness of the disease and availability of diagnostic tools for their detection. Any disease diagnostically accessible seems, of course, to be on the increase. Furthermore, leading causes of death are to be admitted, respected and, within reason, controlled.

People won't give up automobiles because there are 40,000 deaths on the road annually in our country. But it still looks from here as though life expectancy is enhanced among those who are willing to drive carefully and to smoke temperately. Without hesitation we might also add—especially to the blonds, red heads, and sandy complexioned people—that lives, in this and in generations to follow, will be saved by shading the face and backs of the hands from the sky-shine in these States where we are privileged to live!

How Much for a Life?

EVERYONE REMEMBERS the case of Dr. Kris, the physician who allegedly charged too much for spending one hundred hours of professional time to save the life of Benny Hooper, the boy who fell in a well. Criticism of his fee was national, bitter, and unrestrained; most of it probably emanated from critics, both in and out of our profession, who were insufficiently informed. The furor subsided and we assumed the case had been largely forgotten. However, Medical Economics magazine has recently published an article based upon an author's personal research which exonerates Dr. Kris. Unfortunately it will have little or no publicity.

In retrospect, we agree that the publicity was worse than the bill. Dr. Kris had consulted colleagues, including medical society officers, before setting his fee—but he didn't get their sanction in writing. He was under the mistaken impression that a large sum of money was available for Benny's medical expenses. His fee was based upon advice of colleagues according to per diem fees for out-of-town services and confinement and half the going rate per hour for the time of an anesthesiologist, which he is. He had acted, said he, not "as an anesthesiologist—just as a physician." The Hoopers got at least $3,345 from TV appearances and well-wishers. Their take home pay was at least $108 per week. In view of these facts, we believe Dr. Kris proved himself to be sincere, and he was respectful of his profession's public relations second only to the welfare of his patient. Apparently officers of his state medical society, the A.M.A. and the American College of Surgeons acted without complete investigation of all facts and circumstances and the mediation committee of his county medical society decided there would be no bill.

We believe Dr. Kris has a point in principle. Any doctor has a right to render a bill. Plenty of agencies are setting the monetary value of his services and, like the rest of us, he is going along with the worthy plans and wants to see them survive and succeed in defending patients against hardship from unexpected essential medical expenses. However, he resents it when a committee of his own medical society, apparently incompletely informed and under pressure from national medical societies and their officers, tells him there will be *no fee*. This, when he supplied over one hundred hours of services and funds were available without hardship to the family! Who among us would not feel entitled to an equitable fee, subject to adjudication, rather than no fee? It looks from here, through a long hind-sight, that Dr. Kris did get a raw deal and criticism he didn't deserve. He doesn't need the money, but he conscientiously believes in fair and equitable deliberation of professional fees. We'd like to see him vindicated!

CRITIQUE OF THE FINDINGS, CONCLUSIONS,
AND RECOMMENDATIONS OF
THE REPORT OF THE COMMISSION ON

Medical Care Plans*

B. T. Daniels, M.D., Denver†

Any person who attempts to analyze the Report of the Commission will almost certainly do so from a particular point of view.

OUR CRITIQUE EMPHASIZES THE PROBLEM with which physicians in Colorado are currently wrestling. With this in mind and after having studied the entire Report it immediately becomes important to look critically at the Table of Contents in order to see if there cannot be a specific focus of attention.

There is. We here in Colorado are specifically interested in the impact which this report has upon the problems concerning the "Miscellaneous and Unclassified Plans" chapter with which we must deal in our own state. We are also directly interested in the "Judicial Council Opinions and House of Delegates Policy Statements." Such foci of attention will permit us to concentrate on 50 pages of the 96-page Report. That section of the Report entitled "Medical Society Approved Plans, including Blue Shield, and Private Insurance Programs" is of great interest in that many of the observations and the conclusions drawn from them have been well known to Colorado physicians for years. The conclusions of that section strengthen our own convictions, agreeing as we do with the philosophy of Blue Shield and other private, voluntary insurance. We have no real need to tarry over it.

The section on "Industry Programs" turns out to be an excellent summary of what has been happening in industry in Colorado for a long time because of our industrial insurance programs and compensation laws. Here again everyone recognizes that progress and improvement can be made, and although there are specific problems to be worked out, the framework is good. It should be emphasized that such an endorsement does not extend wholeheartedly to all of the *industry related* programs for nonoccupational illness and dependent care that have grown *around* industry, and which are included either specifically or by inference in the section on Miscellaneous and Unclassified Plans.

The Student Health Services section occupies only eight pages of the report, indicating for both the committee making the survey and anyone who studies the report that this is an area where much more experi-

*"Report of the Commission on Medical Care Plans—Findings, Conclusions and Recommendations," published and copyrighted by the American Medical Association as a Special Edition of the Journal of the American Medical Association under date of January 17, 1959. Page numbers and other references to the Report refer to the January 17, 1959, edition; the Report was also previously published in a different format and distributed only to certain officers and Delegates and Alternate-Delegates of the A.M.A. in November, 1958.

Published for widest distribution by order of the House of Delegates of the Colorado State Medical Society at its Midwinter Clinical Session meeting February 20, 1959.

†Chairman of the Grievance Committee's Subcommittee on Panel Practice.

ence is needed before conclusions and recommendations can be offered which have much meaning. This growing aspect of medical care will need to be studied carefully for the next five to ten years, but, for the present, does not demand the attention we now need to give to the section on Miscellaneous and Unclassified Plans.

The final section of the Commission's Report concerns the Judicial Council Opinions and House of Delegates Policy Statements. It also needs to be brought into focus because of its significant relationship to actions which the A.M.A. House might take at its meeting in June, 1959.

It must be recognized that the deliberations of the entire Commission concerning the Miscellaneous and Unclassified Plans (nearly all of our medical care plans in Colorado fall in this category) are based upon the findings, conclusions and recommendations of *only four men,* who constituted one of the committees of the Commission. These four men did all of the research and reporting on this phase of the Commission's work, and it is significant that this one phase occupies nearly *half* of the Commission's total printed report.

250 plans studied

In reading further, please remember this: A total of 250 Miscellaneous and Unclassified Plans were indexed by the Commission's committee. Of these, the committee studied 107 from which questionnaires were obtained, as being representative of a cross section. The committee then evidently felt that its study by questionnaire was not sufficiently revealing; hence a field study was undertaken. The field study was made of 19 plans in ten major cities.

One has the distinct impression from studying the context of this committee's report that most if not all of its findings and conclusions came from these 19 plans. The length of time devoted to each visit was not stated, but the technics used consisted largely of discussion with administrators and employed physicians of the plans and with officers and some members of the medical societies in the areas where the plans were located. We must hope that patients were also interviewed but no direct statement to that effect can be found in the report.

The committeemen found, from their field studies, that there is an infinitely wide variation in the answers to all of the questions they asked. In this connection, bear in mind, again, that this committee's field study concerned only 19 plans in ten major cities.

One has only to examine the 21 subjects included in the Field Studies and Observations section, pages 13 to 33 of the printed Report, to satisfy himself that this infinite variation actually exists. (For our own condensation of these 21 subjects, see Appendix A, attached.)

Many variables

How, then, can sound "conclusions and recommendations" be drawn from such a variety of findings? We are frankly amazed that a commission composed of men whose background of scientiifc training is such as to make them aware of the principles of good investigative processes could recommend anything other than something like: "This group of problems contains so many variables and so many diametrically opposed answers to questions of fact, that conclusions cannot be drawn at this time, and the problems therefore should be approached from some other viewpoint if the entire project is not to be abandoned."

The section presenting a "Statement Concerning Laws Relating to Miscellaneous Type Plans" contains variations just as wide, depending upon the statutes and the court decisions in each individual state. The gist of this entire section of the Commission's Report is summarized in an introductory paragraph:

"The purpose of this section is twofold: to show that as a result of court decisions in some states, legislation, and the changes in social philosophy which have occurred in this country, these miscellaneous prepaid plans, particularly closed-panel plans, can now be legally organized and operated in some states; and to illustrate the variety of laws under which these plans are organized and operated." (Page 35 of the Report.)

The inference of the above paragraph, and of this entire section of the Report, seems clear, namely, a feeling on the part of the Commission or its committee or both to the effect that progressively more and more state laws and more and more court decisions

favor closed-panel medical plans. Nowhere in the Report do we find a plain statement of the fact that a *great majority* of the states prohibit the so-called "corporate practice" of medicine, either by law or by court decision. Nowhere in the Report do we find reference to the most famous court case of all in this general category, the so-called "Painless Parker Case" which originated in Denver and which is still considered controlling by most courts of the country because of the plain precedent then established by the Supreme Court of the United Sttaes. The Painless Parker decision, though a dental case, clearly supports the position the Colorado State Medical Society has asked all organized medicine to take. Whoever advised the Commission on Medical Care Plans legally must have chosen to ignore it, even though courts do not.

The section of the Report dealing with the antitrust laws relating to medical societies is particularly important to Colorado physicians. The committee states on page 37: "One major limitation on an association's control of membership occurs if the association's actions concerning membership have an adverse effect on a business." It is interesting to note that in the A.M.A.-Washington, D. C., case of the early 1940s, the Supreme Court of the United States did not decide whether the practice of medicine is trade or commerce, but approached the problem from a different angle by ruling that the activities of a prepaid plan do constitute trade. Therefore, anything that interfered with that trade must be subject to the antitrust laws.

Question of law

The committee makes abundantly clear the point that the courts universally insist that the word "ethic" does not insulate an association from violations of law.

The 16-year-old Washington, D. C., case, in which the Supreme Court handed down an unfavorable decision against the A.M.A. and the Medical Society of the District of Columbia, has been the basis for fear—sometimes an unreasoning fear and panic—which the A.M.A. has suffered in these intervening years, concerning the application of its ethical principle concerning the Free Choice of Physician.

Colorado physicians can take heart, however, because more recent U. S. court decisions, notably those concerning certain Oregon and Arkansas situations, indicate we need no longer fear court action when medical societies, within reason, select their memberships on a basis of established ethical principles.

The section dealing with Free Choice of Physician develops the historical aspects of this ethical principle, so well known to all Colorado physicians, and it quotes a number of actions by the A.M.A.'s Judicial Council and House of Delegates. One would be well repaid to observe the opposing ideological viewpoints of two members of that four-man committee concerning this principle, as expressed in their footnote comments.

Freedom of choice

The section does conclude with the following statement (page 44) which we heartily approve:

"In summary, the medical profession is determined to maintain the highest possible standards of medical care. Freedom of choice is an important factor in the achievement of this goal."

Underlining this last statement is a footnote by Dr. James M. Reuling, one member of the committee, as follows:

" 'Free Choice' must always stand as a principle, and we should never give up fighting for principles. However, it is going to become only a hollow phrase unless the county societies throughout this country vigorously, and without fear or favor, clean their own house in accordance with Section 4 of the Principles of Medical Ethics*."

Later on in the Commission's Report, the Judicial Council Opinions and House of Delegates Policy Statesments have been discussed at length in a separate section (pages 88 to 91). Some of the conclusions drawn from that discussion need repetition, for instance:

"1. The federated, constituent medical associations comprising the American Medical Association speaking through the A.M.A. House of Delegates have always been mindful of medicine's obligations to the medically indigent;

"2. They have consistently recognized the ne-

*(Section 4 of the Principles of Medical Ethics reads as follows: "The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.")

cessity of preserving the patient-physician relationship without interference from a third party;

"3. They have repeatedly reiterated their belief that no direct profit should accrue to lay groups from the sale of the professional services rendered by physicians;

"4. They have always held (and have recently reaffirmed in the 1957 Principles) that a physician may not in the best interests of the patient dispose of his services under terms or conditions which tend to interfere with or impair the full, free and complete exercise of his medical judgment or skill or tend to cause a deterioration of medical care;

"5. They have maintained that the resolution of the misunderstanding arising out of the economic influences and ethical principles should be resolved locally."

Judicial Council quoted

The Report then goes on to quote the Judicial Council at some length to prove that this same philosophy has guided organized medicine throughout the years. Among the quotes is the now-famous 1927 decision of the Judicial Council—readopted at the 1957 Clinical Meeting in Philadelphia—which said in part after pointing out that contract practice per se is not unethical:

"There are certain points, however, which may be formulated, which when present, one or more of them, definitely determine a contract to be unfair or unethical . . .

"1. When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.

"2. When the compensation is so low as to make it impossible for competent service to be rendered.

"3. When there is underbidding by physicians in order to secure the contract.

"4. When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.

"5. When there is solicitation of patients directly or indirectly."

One serious criticism of the entire Report of the Commission must be noted. This is the tendency of the Commission to make recommendations for courses of action within sections of the Report which are presumably confined to factual conclusions.

An example of this is found under the heading "What is the proper relationship between the medical profession and all third party mechanisms?" (Page 53, at the end of Section V, "Conclusions," which began on Page 47.) This is the way the "conclusion" reads:

"The medical profession should assume a judicious, tolerant, and progressive attitude toward developments in the medical care field. The need for continued experimentation is recognized, and the profession should undertake, and actively participate in, the study and development of various mechanisms for the provision of medical care of high quality."

Although the above quoted paragraph does not mention the free choice principle directly, it affects that principle since much of the "experimentation" in medical care mechanisms in recent years has amounted to modification of those programs which permit them to evade the principle of free choice. Since the above "conclusion" is not a conclusion at all but is a recommendation for a course of action, one of its major effects will be to encourage those who want to dodge free choice, albeit on an "experimental" basis.

Validity of principles

If American medicine is to "experiment" with the American freedom to choose, such action must mean that we are not sure of the validity of that principle. If such *is* the case, let us be intellectually honest enough to say so! If, on the other hand, we are sure of ourselves, let us advance all the reasons for the validity of our principles and immediately proceed to stamp out the rules which permit development or continuance of those programs which evade the principles that made America and American medicine great.

In its section on "Recommendations" for Miscellaneous and Unclassified Plans (pages 92-93) the points listed give a push in the direction which most component societies are already going. However, the direction in recent years has been so unproductive of anything but conflict between medical societies and programs which deny free choice that the push reminds one of a ring of small boys surrounding two who are having a fistic argument! No. A.-7 in that series (page 92) has real merit and will call for imagination and foresight. It states: "'Free Choice of Physician' is an important factor in the provision of good medical care. In order that the principle of 'free choice of physician' be maintained and be fully implemented the medical profession should discharge more

vigorously its self-imposed responsibility for insuring the competency of physicians' services and their provision at a cost which people can afford."

The recommendations directly concerning activities of the A.M.A. are far more helpful, specific and direct, particularly Nos. B.-4 and B.-5 on page 92. No. 4 reads: "In an effort to decrease, or at least to prevent an increase in, the over-all cost of health care, medical care plans should strive toward the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made." No. 5 reads: "Medical schools should be encouraged to devote more teaching time to problems in the socio-economic field of medical care."

We add our hope that such teaching will be done by physicians actively dealing with the socio-economic problems of private practice!

No. B.-16 in this group (page 93) should be reworded, because it indicates the same uncertainty about the free choice principle which is present in other sections of the Commission's Report. No. 16 now reads: "The principle of 'free choice of physician' should be applied as universally as is practicable. Each plan member should have the widest possible choice of physician."

Regimentation or freedom

If a principle that is part of a basic discipline is to be applied only when it is practicable, it will not be applied. The world's history has proved that regimentation and restraint by rule are always much more practicable than are freedom and individual responsibility.

There may be a very real need for organized medicine to reaffirm once again its unalterable dedication to the American principle of free choice. Instead of using such terms as "practicable" and "reasonable" in applying the principle to specific situations, organized medicine should specifically delineate the *exceptions* which will be acceptable to the profession as a whole. These include geographic isolation, charitable situations where medical care is an outright donation, the legal necessities surrounding certain governmental agencies, war and other public emergencies, and perhaps others. The time might come in another generation or two when the list of exceptions would become so long that the principle itself would need modification. For the next 25 years the public and the profession need not be caught in a constant confusion of interpretation.

The casual reader of the Report of the Commission as published under the January 17, 1959, date might easily overlook the fact that it is only half of a two-part publication. Officially it is Part I. Part II was published in May, 1958, and consisted of a separate 180-page volume of "Statistical Appendices and Background Materials" containing as the preface of Part II states: "the results of various surveys and compilations prepared by the staff under the supervision and direction of the members of the Commission responsible for the specific areas of study indicated. . . ." Part II of the Report has had a limited distribution to date.

Credit due the Commission

Considering the report as a whole, much credit is due the Commission for the collection of data which will be most helpful in the deliberations of all echelons of organized medicine.

The interpretation of the data and their effect upon the practice of medicine as regards future actions and programs for the improvement of medical care is a matter for organized medicine to view in the light of its resolute determination to make *quality, not expediency,* its goal. A group of individuals gathering data in a survey will quite naturally draw certain conclusions and may feel compelled to make certain recommendations. These may or may not be accepted by the appointing authority. The data and the conclusions drawn from the data may in fact be so shocking to the appointing authority, as to cause it to redouble its effort to reverse or change trends which the data of the survey might reveal to be present.

The A.M.A. and its component organizations will find little meat for discussion in the *findings* of the Commission. No individual or group is at this moment more qualified than the Commission to say exactly what is happening within the many medical care plans studied. The real nub of the dis-

cussions will be those centered around the conclusions and recommendations referred to previously. The basic problems within these deliberations (including those of our own Colorado House of Delegates) must be the impact which medical care plans are now having and will continue to have on medical practice as they either accept and support, or ignore, brush aside or modify the principle of free choice of physician. Discussions of other aspects of the conclusions and recommendations of the Commission will be largely a matter of endorsement and approval.

We re-emphasize that the first big shock in the discussion area mentioned above comes from the Commission's demonstration of the wide variation in the laws of those states which permit numerous plans to operate under different sets of principles. (See again pages 50, 51, 52.)

Fear of suits

Here, of course, is the point at which ethics and some laws cross. In recent years leaders of organized medicine and their legal advisors have placed so much emphasis upon the need of the profession to avoid conflicts with the law, that the fear of suits or counter suits has confused their thinking as to the real importance of ethical principles to a professional society. The ethical principle of Free Choice of Physician, reiterated many times as being an important factor in the achievement of the highest possible standards of medical care, appears to cross in some states the various legal rules by which the methods of medical practice are determined.

Certainly no lasting good nor honest action can obtain if doctors insist on an ethical principle as being right and at the same time condone a legal rule which permits the abrogation of that principle, no matter in what state the rule exists.

No compromise tolerable

Acceptance of a bad rule because it is law must be only temporary, until enough political and legal strength can be amassed to change the law and the rule. Any other decision can be nothing more or less than appeasement. A compromise of basic medical principles, if they are *right,* is an intolerable two-faced position that can lead only to confusion, irresponsibility, lust for personal power, and, finally, to a deterioration in the science and art of medicine through the default of those brilliant minds who would forsake the struggle because of its fruitlessness. What organized medicine needs to do is to evaluate, and be sure of the truthfulness of, the ethic of free choice! The historical background of the principle as given in the Report shows (pages 43, 44) that organized medicine has clung to the principle for many years. If organized medicine in 1959-60-61 and in all the years in the foreseeable future is still to cling to the ethic, then immediate strength should be amassed, *whatever the cost,* to see to it that the laws of *all* the states are brought into agreement with the ethic. Only time, money, sacrifice, and dedication can hope to accomplish the feat, but with constant, determined, unwavering effort *it can be done.* Only an error in judgment as to the rightness of the cause could defeat it. •

APPENDIX A

(Condensed from Pages 13 to 33, inclusive, of the Report of the Commission on Medical Care Plans, January 17, 1959)

SUBJECT	SUMMARY STATEMENT
1. Physician participation in policy decisions of governing boards.	Twelve plans permitted participation; seven plans did not permit participation.
2. Physician participation in policy decisions on the staff level.	Determined by the medical director with variations as to the amount of advice he received from the staff.
3. Medical Advisory Councils.	Some have and some have not.
4. Lay domination.	Most predominantly lay composed; some entirely.

SUBJECT	SUMMARY STATEMENT
5. Composition and payment of the medical staff.	Composition varies from Generalists to Certified Specialists and pay varies from fee for service to hourly wage or annual salary of $5.50 per hour to $25,000 per year.
6. Scope of the programs and their responsibilities to the patients.	The word "comprehensive" is often used but is just as often not comprehensive. Often there are additional fees for house calls, injections, medications and laboratory services, etc. Treatment for tuberculosis and psychiatric care is often unavailable. Distance sometimes makes a difference. Hospital services are varied. Excluded features often poorly understood by the subscriber.
7. Relationships within the medical staff.	Many and varied but usually a chain of command and responsiblity from Medical Director to Chiefs of Services to other physicians.
8. Relationships between Plan physicians and medical societies.	Some approval and some disapproval.
9. Relationships with other physicians in the community.	Some plans permit free choice, others do not.
10. Extent of physician selection by patients.	Some free choice within the panel after the first visit with regulations for particular situations.
11. Adequacy of facilities.	Satisfactory for the service rendered.
12. Continuity of care.	A difficult problem always under consideration for ways of improvement.
13. Utilization of services.	Varied from 15 to 85 per cent. Difficult to get accurate information on this subject.
14. Preventive medicine.	Most plans mean illness prevention. It is a somewhat over-rated ideal. Most patients present themselves only when they are sick. Immunization programs are about like those in private practice.
15. Relationship of payment for medical services to total income of Plan.	Too wide a variation for good comparison.
16. Record keeping.	Too small a spot check for comparison. Deficiencies were noted; mostly legibility.
17. Complaints and complaint procedures.	Varied widely. Satisfactions varied with the plans.
18. Literature, promotional methods and advertising.	Mail, word of mouth and news media (mostly discontinued).
19. Occupations and incomes of members.	Wide range of both.
20. Attitudes of medical societies toward Plans.	Approval and disapproval side by side.
21. Attitudes of sponsors, members, and participating physicians.	*Sponsors:* There is care where it did not exist before. There is a closer relationship between members and their unions because of the presence of the plans (collective bargaining for medical care). Closed panels insure better continuous quality. The over-all effect has proven beneficial. *Members:* They participate because of the fear of catastrophic illness costs; they like the availability of extras, e. g., dental care, physiotherapy; some are dissatisfied and persuade others not to join. *Participating Physicians:* Part-time employment is good and it is a practice developer; some like or prefer group practice; they can ignore business responsibilities.

As noted in the critique proper, how can sound "conclusions" be drawn from such a variety of findings? The only clear pattern is diversity, wide variation, and contradiction.

Treatment of urinary infections

Wendell H. Hall, M.D., Minneapolis, Minnesota

Relief of obstruction, careful culture technic, and wise choice of antibiotic all help to return the urinary tract to a sterile state.

ALL SERIOUS OR PROTRACTED INFECTIONS of the urinary tract require accurate diagnosis. The anatomical situation and the bacterial agent may be equally decisive in the outcome. Every case requires careful examination of the sediment of a fresh specimen of urine. The unstained sediment should be searched for leucocytes and casts. A Gram stain is helpful to determine the type of predominant bacteria. Presence of bacteria in a stained smear of unsedimented fresh urine indicates probable active infection. Quantitative urine cultures in such cases show a bacterial count of 10,000 or more per ml. Urine should be obtained by catheter from females but in males a fresh mid-stream specimen collected aseptically is preferred.

Urine culture is helpful if properly done. Since the urethra is not sterile and urethral bacteria may multiply rapidly in urine or broth, quantitative cultures on selective agar media are more reliable than broth cultures. Broth cultures often yield only non-pathogenic staphylococci coming from the urethra. Furthermore, broth cultures often show only the predominant organism in a mixed infection. Treatment failures are often due to mixed infections. Selective chemotherapy may suppress the dominant organism and permit the others to prevail. Secondary invaders often possess sufficient virulence to produce continued infection.

Recently we described a simple, rapid method for quantitative urine cultures which provides identification of the bacteria and their antibiotic resistance pattern in forty-eight hours. One-tenth ml. of fresh voided urine is spread on each of two plates of differential agar. After incubation overnight, one plate is examined for Gram-negative bacilli, the other for Gram-positive cocci. The number of colonies is estimated. The bacterial species can usually be identified from the appearance of the colonies. Colonies are selected from the plates for an antibiotic disc resistance test. Experience with this method showed that urine of normal people and patients with glomerulonephritis contained only a few non-pathogenic staphylococci. Urine of patients with active urinary infection usually contained more than 5,000 coliform bacteria per ml. Urine from patients with pyelonephritis contained chiefly E. coli, Aerobacter, Proteus and Pseudomonas. Staphylococci and Streptococci were found only as secondary invaders in mixed infections.

Role of obstruction

The infected urinary tract cannot be sterilized by chemotherapy unless all obstructive factors are removed. Obstruction of urinary flow decreases renal excretion of antibiotics. Urinary obstruction also damages the kidney and makes it more vulnerable to pyelonephritis and cortical abscesses. Early recognition of a ureteral stone may be necessary to control infection and also to prevent irreversible damage to the kidney. Chronic pyelonephritis is more easily prevented than cured. It usually is the result of chronic obstruction and recurrent acute infections.

Selection of chemotherapy

Mild acute cystitis or prostatitis can often

be treated successfully without bacterial identification or antibiotic resistance tests. If the species of the infective organism is known, selection of the best antibiotic can be made without resistance tests with about 80 per cent accuracy. It is in cases of severe, prolonged or mixed infections that resistance tests are most useful. For most acute urinary infections chloramphenicol is the best antibiotic. In resistance cases neomycin one gm. intramuscularly daily for seven days gives excellent results without any cases of deafness. It should not be given in cases with renal insufficiency.

Preventive measures

Early relief of urinary obstruction is the keystone in prevention of serious infections. One should avoid inlying urethral catheters whenever possible. Chemoprophylaxis with oral antibiotics will not prevent such infections. Patients having urethral procedures under an antibiotic "umbrella" frequently acquire a new bacterial flora of resistant organisms which are often equally pathogenic.

In preliminary studies we have had encouraging results with the use of neomycin locally; 0.5-1.0 gm. of neomycin may be used as a solution to irrigate the bladder, or it may be added to tragacanth or an ointment base to lubricate the urethral catheter. To date bacterial infections of the bladder have been avoided in all but one case. Urine cultures have been sterile or have contained only small numbers of non-pathogenic yeasts. •

Abdominal aortic aneurysm

S. W. Moore, M.D., New York*

This paper reviews the history of aneurysms from the time of early Greek physicians through the recent pioneering efforts of American surgeons. Resection technics used in the treatment are described. Homografts and nylon prostheses have been used with good results. Without operation half the patients will die of rupture within a short time. In this series of 35 patients, there was an 11 per cent surgical mortality.

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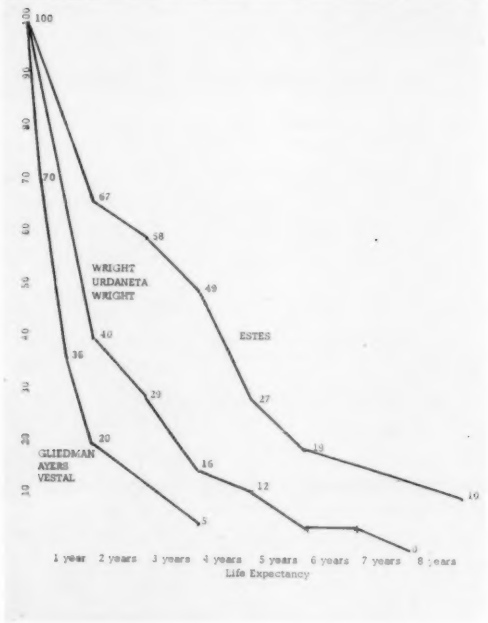
RECENT INTEREST IN SURGICAL TREATMENT of abdominal aortic aneurysms encourages one to review the entire subject, judge the evidence, and then advise patients accordingly. Hippocrates apparently was not familiar with aneurysms. Galen mentioned those resulting from injury, but it is questionable whether he understood the spontaneous aneurysm. Antyllus first practiced proximal and distal ligation for aneurysm. Rudolf Matas in 1909 stated that it was unlikely that aneurysm of the aorta would ever be operated upon successfully, but two years earlier, Carrel in 1907 had predicted that they could be removed with the vessel, and the excised segment replaced by a graft from another human being.

Recent history

Successful ligation of a patent ductus arteriosus by Gross of Boston in 1939 provided

CHART I

Abdominal Aortic Aneurysm
Life Expectancy



the real impetus to vascular surgery. Then in 1945 Gross and Crawford independently reported successful resection of the aorta for coarctation. By this time antibiotics, blood banks, and better anesthesia had become available. Eleven years ago, in 1948, Gross used homologous grafts to bridge gaps in the aorta after excision of long coarcted segments. In 1949 Swan excised the coarcted segment of an aorta together with an associated aneurysm and repaired the defect by a homologous graft. Apparently this was the first aneurysm of the aorta to be removed and replaced by a graft. Dubost in 1951 was the first to deliberately attack a large abdominal aortic aneurysm, remove it, and restore the vessel by a homologous graft.

Many series of patients with aortic aneurysm have been reported. Some of these are autopsy reports, and others are selected groups. Pertinent material regarding prognosis of abdominal aortic aneurysm is scarce. Estes has reported on the life expectancy of 102 patients seen at the Mayo clinic (Chart I). While 67 per cent survived one year and 58 per cent survived two years, only 19 per cent survived five years and 10 per cent eight years. In a series of 68 patients from The New York Hospital, Wright found that 40 per cent lived one year, 30 per cent two years, and 5 per cent five years. Gliedman, Ayers, and Vestal are even more pessimistic in their report from Kings County Hospital in Brooklyn, New York. They report 68 patients with 96 abdominal aneurysms, 72 of which were aortic. In this group 80 per cent were dead within one year of the onset of symptoms, and 49 per cent died from a vascular rupture.

Causes

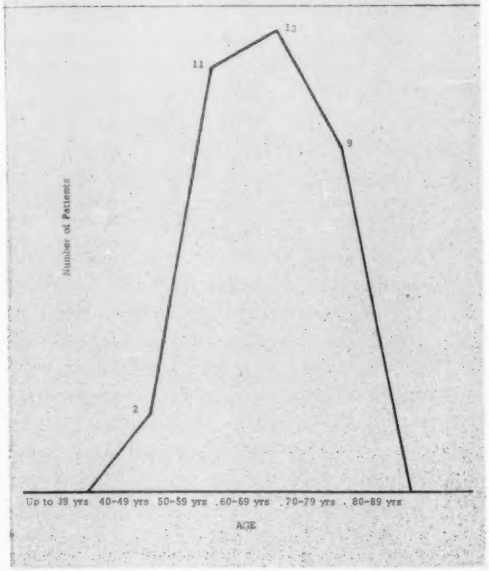
Aneurysms in the chest have long been considered almost entirely syphilitic. In a series of 365 cases of aortic aneurysms, Blakemore found that of 192 syphilitic aneurysms, 182 occurred in the thoracic and only 10 in the abdominal aorta. On the other hand, those in the abdominal portion of this vessel were largely arteriosclerotic. With the diminishing incidence of syphilis and the increase in the longevity of the general population, arteriosclerosis is becoming even more significant as a cause of aneurysms, particularly those in the abdominal aorta. These occur in the older age group and almost entirely in the years from 50 to 80 (Chart II). All save two of the 35 patients we have operated upon were in this range, and 22, or 63 per cent, were over 60 years of age. Males outnumber females 29 to six or almost five to one. This is true in all reports, and there is no clear explanation of this fact.

Arteriosclerosis causes arteries to elongate and to become tortuous, as observed in the aged. The abdominal aorta is fixed both as it passes through the diaphragm at its bifurcation. Because of this fixation at two points, as the aorta elongates in the formation of an aneurysm, it must deviate from the midline. This deviation, which can be seen readily by x-ray, is usually to the left, sometimes to the right, and in other cases seems to come straight up from the spine. In the last group they are much easier to palpate and can frequently be seen to pulsate.

These aneurysms are frequently found on routine physical examination of asymptomatic patients. When present, the most com-

CHART II

Abdominal Aortic Aneurysm
Age



mon symptom is pain, usually in the abdomen but often in the back. At times patients point out the pulsating mass in the abdomen, and some have complained of their "heart beating in the stomach." Pain is particularly important as a prognostic sign because it may indicate rapid, progressive enlargement or rupture. Sometimes pain the back accompanies erosion of lumbar vertebrae.

Physical findings

The usual physical finding is an expansile, pulsating mass in the upper abdomen. It is usually on the left, but may be on the right and may in either case extend into the pelvis. Aneurysms are frequently multiple, and with one in the abdominal aorta there may be one, two, or three in the iliac vessels. The mass may be non-tender and movable, but with perforation it becomes fixed and tender. Characteristically aneurysms start one to two centimeters below the renal arteries, are fusiform in shape, involve the bifurcation, and extend into one or both common iliac arteries. The large majority in this series were diagnosed by physical examination, but it is interesting that four were found at operation for other abdominal conditions. Except in the case of small aneurysms, diagnosis presents no problem to the experienced examiner.

X-ray findings

Roentgenologically, the diagnosis may be made by means of the shadow in the left side outlined with a rim of calcium. A lateral film should always be made, as this will get the spine out of the way and may even show erosion of a vertebra missed on the anteroposterior view. In the past we used aortograms routinely to establish the diagnosis. While this is helpful in many ways, experience has shown that in most cases it is not necessary. Furthermore there are disconcerting reports of harmful effects from the procedure, particularly renal injury and spinal cord damage. It should be pointed out that experience is necessary to interpret aortograms and that normal ones are not seen in patients with aneurysms.

These patients are in the older age group and they therefore have a high incidence of associated disease. As one would expect the arteriosclerosis is generalized and not confined just to the abdominal aorta. Of the 35 patients in our series, 45 per cent had electrocardiographic evidence of coronary artery disease or old coronary occlusion, many had a history of minor strokes, and 74 per cent had a blood pressure under 150 systolic. Five patients had peptic ulcer and five had diverticulosis.

Rupture of the aneurysm causes death in about 50 per cent of patients with abdominal aortic aneurysm, and without operation it is always fatal. There is frequently a warning, but this is short and death is sudden. Many have been saved by emergency operation, and this should be attempted.

With the above in mind, there are few contraindications to operation as soon as the diagnosis is made. Age is not a contraindication as these patients are in the older age group. The majority do not have hypertension and even when it is present, this is not a contraindication. Since postoperative death is usually caused by renal or cardiac complications, these symptoms should be carefully evaluated beforehand. continued on next page

Surgical procedure

Most surgeons use almost the same procedure in operating for aneurysm. The abdomen is opened through a long incision, and usually we retract the left rectus muscle. After mobilizing the ligament of Treitz, the small intestine is placed on the abdominal wall on the right, thus giving excellent exposure. The peritoneum is divided in the midline over the aorta and the division carried down over the iliac arteries. Carefully carrying the upper incision upward, the left renal vein is visualized. Dissection is carried down onto the aorta and then upward to give sufficient room above the aneurysm for an anastomosis. We usually like to see or to palpate the renal arteries to know just how close they are. After careful dissection a tape is placed about the aorta above the aneurysm. Going below, the iliac vessels are evaluated for aneurysms, calcification, or thrombosis, and then are freed. One must be careful not to injure the veins, since bleeding from these vessels is more troublesome than that from arteries. A Satinsky clamp is placed about the aorta above and clamped. The iliac arteries are divided between clamps close to the aneurysm.

Dissection is started from below, lifting up the vessel and working from beneath. At times the veins, and in particular those at the junction of the common iliac veins and lower inferior vena cava, are intimately fused with the artery or aneurysm, in which case the adventitia of artery is left on the vein. As the lumbar arteries are visualized, they are divided between clamps and both ends ligated. In certain cases, this cannot be safely carried out because of danger to the inferior vena cava. In such a situation the aneurysm is opened completely, and removed in sections, leaving a section attached to the inferior vena cava. All the inner coats of the artery can then be removed by blunt dissection. At times bleeding from lumbar arteries is troublesome. A small, curved clamp inserted into the mouths of these lumbar arteries stops bleeding and makes it very easy to find them posteriorly, where they are then ligated.

After cleaning the field of all clamps and controlling bleeders, the upper aorta is prepared for suture and any calcium plaques are removed. The distal vessels are prepared. It may be necessary to ligate certain internal iliac vessels in case of aneurysm or advanced disease. In other cases an end-to-side anastomosis into the external iliac artery will allow blood to flow into the internal iliac. Certain patients require that both internal and external iliac vessels be anastomosed. We do not like to anastomose both internal and external iliac on the same side, nor do we wish to ligate an internal iliac but each patient is different and these decisions must be made.

Homografts and protheses

Homografts were used in 21 patients. These give a good bifurcation of the common iliac artery, but usually are not long enough to reach the femoral. It takes time to prepare them and to ligate vessels. Despite these disadvantages we have been pleased with homografts and, except in one patient who developed infection in a suture line, ruptured, and died of hemorrhage, we have had no trouble with them. Edward-Tapp nylon protheses have been used in ten patients. These are more readily available, do not have to be prepared save for fusion of the cut end with cautery, are longer, and are faster to suture. They bleed more through the suture line and the prothesis itself. We have had no difficulty with this means of replacement.

While the preparation is being carried out, the distal vessels are opened to test for back bleeding, and heparin solution is injected into the artery to prevent clotting. Using 0000 arterial silk, two sutures are started posteriorly. Going over and over through all layers, they are continued anteriorly and tied. This proximal anastomosis is tested, and if necessary an additional suture is used to stop a leak. Usually we do the right distal anastomosis first, using 00000 arterial silk in a like manner to the proximal suture. After filling it with heparin solution, the left common iliac of the graft or prosthesis is occluded. The distal clamp is removed and there is back filling into the graft or prosthesis. Usually there is very little leakage and it can be stopped with pressure or an additional suture. The proximal clamp is released slowly, and as this causes a drop in blood pressure, a

transfusion is now started. Until this time blood is usually not necessary. The left anastomosis is carried out in the same manner as the right.

In removing the aneurysm, it is necessary to ligate the inferior mesenteric artery. At times this is thrombosed as a result of the aneurysm. It should always be visualized at its origin and ligated close to the aorta to preserve the left colic artery, whose ascending branch anastomoses with the mid-colic and forms the marginal artery of Drummond. As the inferior mesenteric artery is ligated, blood supply to the lower large intestine comes from the internal iliac arteries and the mid-colic artery. For this reason we are loath to ligate the internal iliac artery on either side, more so to ligate both. Dual ligation was done in one patient, and there was some necrosis of the mucosa of the sigmoid. When one internal iliac artery is ligated, there may be severe pain in that hip and upper thigh for some time, particularly at night. Since arteriosclerosis is generalized, there is frequently diminished circulation in the legs and some narrowing of the femoral vessels, and a bilateral lumbar sympathectomy is therefore done.

Mortality

In all, we have operated upon 35 patients (Chart III). Two of these were not resected as the aneurysm was diffuse, and we did not think operation would help. Three had rupture, and one of these survived. In the 30 patients without rupture who were resected, there were two hospital deaths, a mortality of 6.6 per cent. These patients usually do well from the start. If, however, a complication arises, it is usually fatal. None of these patients had amputations, but one had the abdomen reopened on the table and an anastomosis redone. Another was taken back from the recovery room and a blocked anastomosis repaired.

All four hospital deaths occurred in patients with heart disease as shown by electrocardiogram, and three of these had suffered coronary occlusion in the past (Chart IV).

CHART III

Abdominal Aortic Aneurysm
Total Experience With 35 Patients

	Number	Deaths	Mortality
Explored only	2	0	0%
Rupture	3	2	66%
Nonrupture	30	2	6.6%
Cases resected	33	4	12%
Total cases	35	4	11%

CHART IV

Abdominal Aortic Aneurysm
Electrocardiogram Evidence of Coronary Artery Disease or Bundle Branch Block

Cases Resected	Cases	Deaths	Mortality
Nonrupture			
No heart disease	13	0	0%
With heart disease	19	2	10%
With rupture			
All with old coronary occlusion	3	2	66%

Twenty-nine patients were discharged alive from the hospital. These have been followed for periods ranging from less than six months to four years (Chart V). Three patients have died. One, a physician, developed an abscess at a distal anastomosis, the suture line gave way, and he died of hemorrhage two weeks after leaving the hospital. The first patient we operated upon died of coro-

CHART V

Abdominal Aortic Aneurysm
Follow-up

	Total	Living
With rupture	1	1
Nonrupture	28	25
Less than 6 months		6
6 months		5
12 months		2
18 months		3
2 years		3
3 years		3
4 years		4

One died of abscess of suture line at 6 weeks.
One died of coronary occlusion at 3 years.
One died of carcinoma of cervix at 2 years.

nary occlusion three years later. Another died of carcinoma of the cervix at two years. All others were well at the most recent follow-up. Many of these patients had retired before operation, and as this is a generalized, progressive disease the number at active manual labor is not great. Although all deaths occurred in patients over 60, we do not think age in itself is a contraindication to surgery.

Summary

1. Abdominal aortic aneurysm is one complication of progressive, generalized arteriosclerosis. Coronary occlusion, hemiplegia, and other vascular occlusions, particularly in the legs, can be expected.

2. Without operation, half these patients will die of rupture of the aneurysm in a short time.

3. With rupture, the operative mortality is high, but without operation death is inevitable.

4. These patients can be operated upon with a low mortality, be relieved of the fear of rupture of the aneurysm, and resume a normal life. •

REFERENCES

[1]Estes, J. E.: Abdominal Aortic Aneurysm: A Study of 102 Cases. Circulation 2:258, 1950.

[2]Wright, Irving S., M.D.; Urdaneta, Enrique, M.D.; and Wright, Barbara, B.S.: Reopening the Case of the Abdominal Aortic Aneurysm. Circulation 13:754, 1956.

[3]Gliedman, Marvin L.; Ayers, William B.; and Vestal, Betty L.: Aneurysms of the Abdominal Aorta and Its Branches—A Study of Untreated Patients. Ann. Surg. 146:207, 1957.

[4]Dubost, Charles; Albary, Michel, and Oeconomos, Nicholas: Resection of an Aneurysm of the Abdominal Aorta. Arch. Surg. 64:405, 1952.

[5]Moore, S. W.: Resection of the Abdominal Aorta With Defect Replaced by Homologous Graft. Surg. Gynec. & Obst. 99:745, 1954.

[6]De Bakey, Michael E.; Cooley, Denton A.; Creech, Oscar, Jr.: Treatment of Aneurysms and Occlusive Disease of the Aorta by Resection. J.A.M.A. 157:203, 1955.

Definition of mastectomy

Thomas J. Foley, M.D., Milwaukee, Wisconsin

Survival rate following treatment of breast cancer at the end of five years is poor—about 50 per cent. Cure depends upon total removal or destruction of the tumor, yet the term mastectomy is ill defined. Here is light upon the subject.

THE RADICAL MASTECTOMY has been accepted universally as the optimum surgical treatment for operable carcinoma of the breast. This has been true for the past 50 years with few exceptions. During the past ten years there has been growing dissatisfaction with the present cure rates for treated carcinoma of the breast—only about one-half of the treated patients are living five years after treatment in any hands. As a result, new surgical technics have been introduced and practiced which vary from the standard radical mastectomy. Still, many hospital records speak only of a "mastectomy" or "radical mastectomy" as having been performed on the patient. It is our purpose briefly to describe and discuss some of the different methods of mastectomy in order to achieve greater clarification of the term.

Halsted-Meyer radical mastectomy

Historically, Halsted and Meyer began describing an operation which was more radical than the current mastectomy, in about 1894. Halsted's main purpose was to reduce the high (50-85 per cent) local recurrence with the simpler mastectomy then in vogue. He began removing both pectoral

muscles and cleaning out the axilla. He used a wide skin edge and a thin skin flap. Over the years following his first description of the operation, he made frequent changes in his operative technic. The result is that his students have passed on to our generation of surgeons an operation which bears his name and incorporates his principle of wide en masse excision of the tumor with the axillary lymph drainage. It is interesting to note that he frequently removed the supraclavicular area and made comments about the advisability of removing the internal mammary chain of nodes also. He was a meticulous surgeon who strictly insisted upon careful technic. Out of all this has come an operation which includes thin skin flaps with no subcutaneous fat, wide skin edges, making primary closure difficult and grafting the rule, complete removal of the pectoralis major and minor muscles, sharp dissection of the entire axilla below the axillary vein, leaving only the long thoracic nerve and thoraco-acromial nerve and the bare chest wall. The operation should take four hours in expert hands.

Simple mastectomy

In the simple mastectomy, only breast substance and the overlying skin are removed. There is no real skin flap, and closure is easy and certain. The operation is rapid, relatively bloodless and easy on the patient and surgeon. There is less morbidity, particularly from the standpoint of wound healing and arm edema, a point that allows immediate and intensive radiotherapy. Some operators remove palpable axillary lymph nodes, without, however, a careful axillary dissection.

The "American" mastectomy

Somewhere between the simple and radical mastectomy there is another operation. One finds it difficult to describe or define it, but no one can deny its popularity. Haagensen has called it the "American" mastectomy. The skin flaps in this operation are thicker and contain some subcutaneous fat. This leaves a flap that has a yellow color in contrast to the white color of the Halsted skin flap. The skin margins vary, but should be of about four fingers' breadth from the palpable lesion. The clavicular portion of the pectoralis major may be left on the chest with the cephalic vein. The entire contents of the axilla are removed, usually by sharp dissection, not the "grab what's palpable" method sometimes associated with the simple mastectomy. The skin flap is closed without tension and usually heals primarily, allowing x-ray therapy to be started within two weeks.

The super-radical mastectomy

Whether in New York, Stockholm, Minneapolis, Rome or London, this operation is designed to remove surgically en bloc the internal mammary and/or the supraclavicular lymph drainage of breast carcinoma. Urban has reported and practiced an operation which, by including resection of a large portion of the anterior chest wall, removes en bloc and in continuity with the tumor the internal mammary chain of nodes from the first through fifth intercostal space. The chest wall defect is closed with a fascia lata graft. His operation takes four to five hours. In 215 cases he has had one postoperative death. Wangensteen has devised, and in 64 selected cases performed, a two-stage operation which includes dissection of the supraclavicular space, the upper mediastinum and the internal mammary nodes. However, he had a high operative mortality (12.5 per cent) with these cases. A combination of Wangensteen's neck and supraclavicular dissections with Urban's chest wall resection is practiced by Noel, who, to facilitate the dissection en bloc, removes the clavicle as a primary procedure. Both Dahl-Iversen and Margottini expose and remove the internal mammary chain of nodes by cutting through the second, third and fourth costal cartilages and raising the chest wall. In a new technic for dissection of the internal mammary chain developed by Handley, the pectoralis major is preserved and used to cover the chest wall defect.

Discussion

Two factors stimulated us to attempt a closer definition of the term "mastectomy." One was that during a survey of survival rates after simple mastectomies, we came across several cases that claimed to have been radical mastectomies whereas in our

opinion they were closer to simple mastectomies. The other factor was that figures, obtained from the Blue Shield office, revealed that out of 509 mastectomies performed in Milwaukee County over a given period, 212 were simple mastectomies.

Many *doctors who are not surgeons* are vitally interested in a careful definition of what type of mastectomy is being done on their patients. Also, we now have a high proportion of well qualified *radiotherapists* who are interested in breast cancer; they want to know when they may give radiotherapy and how much. *Neurosurgeons* are now removing the pituitary gland in rare far advanced cases. Chemotherapeutic agents have been developed which are helpful in some breast carcinoma; this should encourage *internists and general practitioners* to treat breast cancer and its recurrence. A surprisingly high number of those doing breast surgery need to re-define just what type of operation they are doing.

Conclusions

Results of treating breast cancer today are unsatisfactory. Surgery is a foremost method of treating this disease, but the type of operation done is not a constant. The surgeon is now relying more and more on other specialties to aid in treating various stages and types of breast cancer. A more exact definition of the surgical procedure is in order. •

Rocky Mountain Radiologic Conference August 20-22, 1959

The Rocky Mountain Radiological Society announced its annual conference will be held August 20-22 at the Shirley Savoy Hotel, Denver.

Guest speakers who have accepted invitations to appear on the program and the titles of their papers are:

Eugene P. Pendergrass, M.D.: "Some Intangibles Concerning Cancer"; "Some Thoughts Concerning the Treatment of Carcinoma of the Breast"; and "Pneumoconiosis."

Philip J. Hodes, M.D.: "Altered Cerebral Hemodynamics"; "Manifestations of Intracranial Disease"; "Rare Pulmonary Diseases; Their Roentgen Manifestations"; "Medical Meddlers; What Price Insecurity."

Franz Buschke, M.D.: "The Treatment of Advanced Carcinoma of Head and Neck"; "Common Misconceptions in Radiation Therapy."

Owings W. Kincaid, M.D.: "Abdominal Aortography"; "Experiences With Angiography as a Guide to Mediastinal Exploration"; "Roentgenologic Diagnosis of Operable Heart Disease."

Magnus I. Smedal, M.D.: "Therapeutic Uses of Low Megavolt Electrons"; "Observations on the Cause of Arm Edema Following Radical Mastectomy."

All physicians are invited to attend this program. Additional information can be secured by writing Dr. Raymond W. Hammer, 452 Metropolitan Building, Denver 2, Colorado.

Postgraduate Refresher Course

The University of Southern California School of Medicine announced another Postgraduate Refresher Course in Honolulu for July 29 through August 15, 1959. Travel arrangements for the course can be made either aboard the S.S. Lurline or via United Air Lines to Honlulu. Those physicians who elect to travel by sea will be offered several courses on board ship. A variety of topics have been arranged which will most suit the individual physician's needs. In addition to lectures there will be workshops in ECG and x-ray diagnosis as well as water and electrolyte balance and the diagnosis of jaundice. Emphasis is placed on practical diagnosis and therapy.

Physicians and their families may elect to use a combination of air and sea travel going to and from Hawaii. For further information regarding curriculum and travel brochures, please write to Dr. Phil R. Manning, Associate Dean, Director, Postgraduate Division, School of Medicine, University of Southern California, 2025 Zonal Avenue, Los Angeles 33, California.

Food for thought

Who is wise?
He that learns from everyone.
Who is powerful?
He that governs his passions.
Who is rich?
He that is content.
Who is that?
Nobody. Benjamin Franklin

The gold rush —its cost in health and life

Theodore E. Beyer, M.D., Denver

A rare and thoughtful narration upon the turbulent years in the conquest of the West. It eulogizes the brave men and courageous women who now rest beneath the rocky soil of our mountains. For many, there were too few years between Born ....., and Died ..... .

To THE TOURIST exploring the ghost towns of Colorado, the cemeteries of Gilpin County present a mute history of the health hazards of the earliest gold mining community of the state. Here, in the barren, windswept Rockies repose many of the hardy pioneers who came west in the picturesque gold rush of a century ago. Here is depicted the bewildering story of a generation of courageous men and women who established a prosperous commonwealth and opened up an unexplored region to the world and to civilization.

There are five cemeteries in and about Central City, Black Hawk and Nevadaville which are in most respects quite similar. Due to the rocky character of the ground, the graves are spread over wide areas. There are no pretentious mausoleums here, no tombs or memorials commemorating the powerful and the renowned, no heroic epitaphs extolling deeds of glory and of valor. On the contrary, many of the graves are unmarked and numerous marble headstones are crumbling with age. Here and there is a sunken plot surrounded by a dilapidated wooden or wrought iron fence and thickly overgrown by grass and trees. Even the wooden crosses have served their purpose for their names and dates have been effaced by wind and snow. The whole scene is one of desolation and decay.

Yet, there is a tragic story here which has not been accorded a place in the annals of that period. Many infants and children lie buried here. In one grave rest mother and child; in another repose three children of one family. Nearby are three marble markers all bearing the same date. These and many others confirm one's impression that a virulent epidemic of diphtheria had ravaged this unprotected community in 1879-80. The toll exacted by this harbinger of death will, however, never be known for there are no available vital statistics. Nor are there any official Board of Health reports or records in the medical journals of that day. Even the Press failed to recognize or admit the obviously contagious character of a disease that was raging in this and neighboring counties. True enough, laconic reports of deaths from "croup" or "sore throat and pneumonia" appear rather frequently but their significance was not recognized and their import failed to arouse either official or editorial comment.

Centers of population

Obviously, one of the factors contributing to the development of epidemics in pioneer communities was the concentration of population from all parts of the country into a restricted area. Even Denver experienced severe epidemics of typhoid and diphtheria in 1879 and 1890. Then, too, the age of pre-

Typical markers on their way back to dust. John Johns reached his expectancy of life—37 years!

ventive medicine was still in its infancy. Incredible as it may seem, doctors were still debating the contagiousness of tuberculosis. While Pasteur, Koch and others had currently ushered in the golden age of medicine by their discoveries in bacteriology, the principles of vaccine prophylaxis and serum therapy had not as yet been discovered. Despite vigorous outdoor living in a salubrious climate the pioneer families of this era had little or no immunity against the spread of communicable disease.

Unique markers

Other memorials that depict the medical history of this frontier community are those erected to the young and middle-aged men who died of miners' consumption. Unique markers such as this appear on all sides.

William Henry Williams
born in
Cornwall, England
died
May 11, 1877
aged
44 years.

Many of the hard rock miners came from foreign countries, especially England. Among these, the so-called "Cousin Jacks" from Cornwall enjoyed an enviable reputation of skill and proficiency.

In attempting any serious study of the incidence of silicosis during this period the search for vital statistics is unrewarding. However, the numerous obituaries appearing in the Register-Call of Central City indicate that the mortality rate was little short of appalling. An analysis of 50 cases taken at random from the files of 1879 brings out the startling fact that the average age at death was less than 38 years, identical to that reported from other hard rock mining districts such as Joplin, Missouri, and the Rand in South Africa.

Many factors contributed to the high incidence of miners' phthisis in Gilpin County. Effective methods of protection against the insidious, deadly effects of quartz dust inhalation had not yet been devised. Respirators designed to filter the air proved to be cumbersome and inefficient. Moreover, the "dry method" of mining, long since discarded, favored the dissemination of dust. Finally, it must be noted that legal controls of industrial conditions of hard rock mining were not enacted in Colorado until 1899. It was a far cry from present day safeguards instituted by the United States Public Health Service, which calculates the actual silica content of dust and restricts work accordingly.

The contribution of the medical profession toward the control of occupational diseases was, perforce, negligible. Diagnostic methods were inadequate to discover incipient pulmonary lesions still amenable to treatment. Without the employment of modern x-ray technics medical science could not be applied to the basic solution of the problem.

Hazards accepted

In a final analysis, silicosis was part and parcel of a "laissez faire" regime characteristic of all gold mining camps. In an age of turmoil and achievement, of prodigious energy and gigantic production of wealth, the hazards of life were accepted with Oriental fatalism. Unlettered men entered the routine struggle for existence with passive resignation. Their sacrifices have been forgotten. The monuments erected to their memory are not commensurate to their contributions to society.

Perhaps the most impressive memorial in Westminster Abbey is the tomb of the "Unknown Warrior" commemorating the nation's costly sacrifices during World War I. The tomb is situated beneath the floor in the center of the nave. Visitors seemingly step about softly here and often linger long enough to read in full the epitaph couched in beautiful Shakespearean language: "Beneath these stones rests the body of a British warrior, unknown by name or rank, brought from France to lie among the most illustrious of the land—."

Who will write an appropriate epitaph to the hard rock miner of the Rocky Mountains? •

Chronic simple glaucoma

Albert L. Schonberg, M.D., Albuquerque, New Mexico

Practical insight into the general practitioner's role in the early diagnosis of this leading cause of blindness.

GLAUCOMA, THE LEADING CAUSE OF BLINDNESS after the age of 40, continues to be a diagnostic dilemma, particularly in the hands of the general practitioner or internist. When a patient presents himself for his annual physical examination the physician is often haunted by the realization that his capacity for ruling out this disease is limited. Admonitions regarding early diagnosis have given rise to confusion in the mind of the sincere diagnostician. Does the absence of eye pain, rings around lights, reduced vision, and a tactile soft globe rule out the disease? Obviously, no. The presence of actual eye symptoms leads the patient to the ophthalmologist without delay as a rule. A survey in the city of Albuquerque revealed that even among our top flight internists, no real effort is yet being made to rule out asymptomatic chronic simple glaucoma. Generally, the patient may be questioned about eye symptoms and digital pressure of the eyes ascertained. Tactile tension determination has been proved utterly useless and misleading unless we are dealing with an extremely high ocular tension, which, of course, is not the case in early chronic simple glaucoma. Unfortunately, glaucoma is a much classified and reclassified disease, but I do not feel that this need concern us here. Let it be assumed that if the patient has eye symptoms he should be referred to an ophthalmologist. That leaves us with a group of patients who have good vision, are symptom free, and have early chronic simple glaucoma. This form of the disease, even in the care of a competent ophthalmologist, is an insidious and wily foe which strains one's diagnostic acumen to the utmost. As in general medicine where early diagnosis of mild diabetes or early hypertension must be based on arbitrary levels of what is normal, so also in glaucoma we have placed arbitrary limits on what is considered normal ocular tension. A high "normal" ocular tension calls for repeated testings of pressure, provocative tests, field and tangent screen tests, gonioscopy, and measurements of facility of aqueous outflow. Where does this leave the general practitioner who is already beset with overwhelming problems in all the fields of medicine?

In an effort to answer this question an excellent inexpensive instrument called the Berens Tolman tonometer[1] has been offered and perhaps, if universally accepted and used, it would add many patients to the roster of those upon whom a diagnosis of early chronic simple glaucoma has been made. Unfortunately, the use of this tonometer is not general and in many cases where they have been purchased they lie untouched in a drawer after a few trials. Frankly, I do not believe that the average generalist feels comfortable in doing a routine anesthesia of the cornea and then applying any form of instrumentation to the corneal epithelium, which after all is quite easily abraded. In addition to this, many patients do not accept the procedure gracefully and will wince, squeeze, refuse to fixate, and thereby provide readings totally unreliable and misleading. Still further, the difficulties in maintaining a sterile instrument for several tests

in an afternoon must be met and the prevention of cross contamination is not easy. To those who have mastered these problems and who have even gone a step further and are using the more accurate Schioetz' tonometer, I offer my congratulations and recommendation that the procedure be continued. To those who have not done so yet, but who are willing to try, I say that it is a worthwhile and commendable effort.

Retina examination

Because of the drawbacks of the technic mentioned above and because general acceptance seems unlikely, I should like to suggest still another approach to the problem. I think that it is safe to say that most internists and general practitioners own an ophthalmoscope. What is more, I think that most of them use an ophthalmoscope during a routine physical examination. Some, I feel, use them quite well but I do know that many physicians use them more or less ritualistically, satisfying themselves with normal acting pupils through which, because they are small, they obtain little or no information from the inside of the eye. The relatively rare generalist who does excellent ophthalmoscopy quickly dismisses the optic disk after he has satisfied himself that it is not choked and turns his attention to the retina, the presence or absence of hemorrhages or exudates and then the condition of the retinal vessels. It is an admirable thing, indeed, when a physician not devoted to the practice of ophthalmology can find a solitary diabetic aneurysm to help establish a diagnosis of the mild form of the disease; but it must be remembered that most eye findings from the internist's examination are of a confirmatory nature and that, for example, hypertension can more easily be determined with the sphygmomanometer or glomerulonephritis by a urine examination.

But let us return to the average busy generalist who must of necessity jealously guard his working moments. It is not my intention to impose anything new or time consuming upon him, but rather to use fruitfully those fleeting seconds when, as part of a general physical examination, he picks up his ophthalmoscope.

After visual acuity is taken and with the patient still seated, have him fix his attention upon an object across the room and in direct line with his forward vision. Tell him that he is to keep both eyes open; his distant fixation, which must be as absolute as possible, will keep his pupils reasonably open. Place the ophthalmoscope in your right hand and use your right eye when examining the patient's right eye. Keep your ophthalmoscope as vertical as possible, as this will prevent your getting your head in the line of vision of the fixing left eye. Coming in from the temporal side and with your head level with that of the patient, you will easily find the most obvious landmark in the fundus, the optic nerve head. Your right index finger should be on the knurled rotating drum of lenses on the ophthalmoscope. Having found the nerve head, rotate the lenses with your index finger until you find the one which gives you the greatest clarity. Use your left eye and your left hand when examining the left eye.

Sugar[2] mentions that the earliest changes in the disks are recognizable ophthalmoscopically only by comparison with the other disks and by comparison with a previous description of the disk if this is available. He suggested expressing the description as a fraction with a numerator indicating the relative horizontal diameter of the cup as compared with the horizontal diameter of the disk written as the denominator. He added that a rough sketch of this relationship is even better.

For purposes of recording I have divided physiologic cupping into four general groups*, Classes I, II, III, IV:

Class I: The one with the least amount of cup. The cribriform plate at the bottom of the disk cannot be seen and the vessels appear to come out centrally from the optic nerve.

Class II: The commonest variety of physiologic cup. A good solid edge of pink optic nerve is seen nasally, but the cribriform plate or lamina cribrosa can be seen glisten-

*A. Elschnig (in Encyklopadie der Augenheil Kunde—Leipzig, 1904) originally classified physiologic excavation into five large groups. Reference was made to (1) the lamina cribrosa, (2) bifurcation of central artery, (3) position of vessels, (4) inclinations of walls, (5) conus formation, (6) formation of central vein. For purposes of simplicity, my classification deals principally with the width of the cup. Please note that the depth of the physiologic cup is not important in this classification.

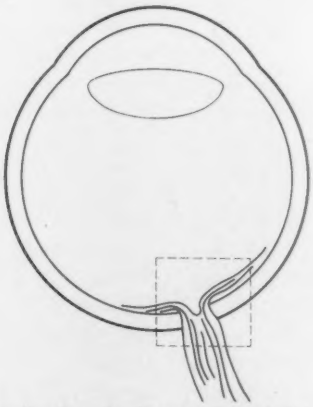
ing white at the bottom of the cup and this may slab off temporally. The vessels coming out of the nerve head roll gently over its edge.

Class III: Presents a more striking picture. The cup is wider, leaving less nerve edge, but the vessels are not precipitous.

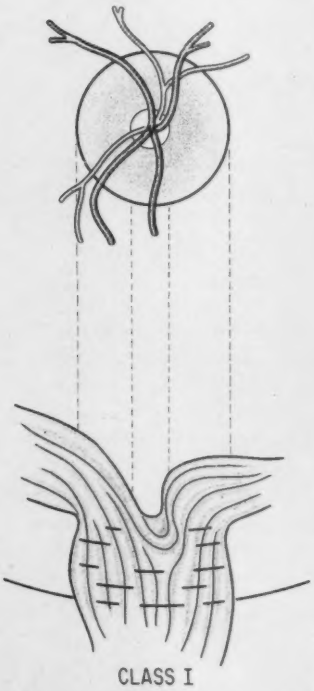
Class IV: Even more marked in the size of the cup, and this eye is definitely suspect of glaucoma which should be ruled out by all means available.

In my own practice I have been classifying these cups according to the above description and I feel that it has several ad-

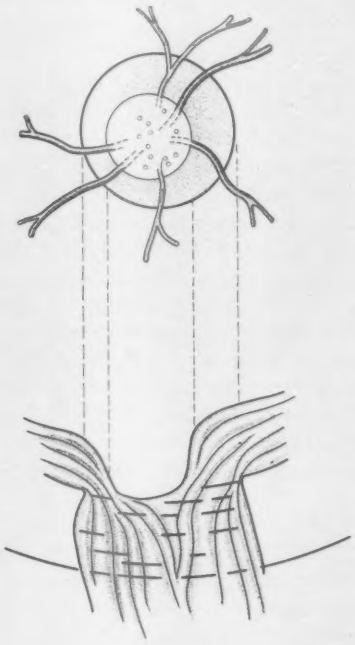
continued on 68



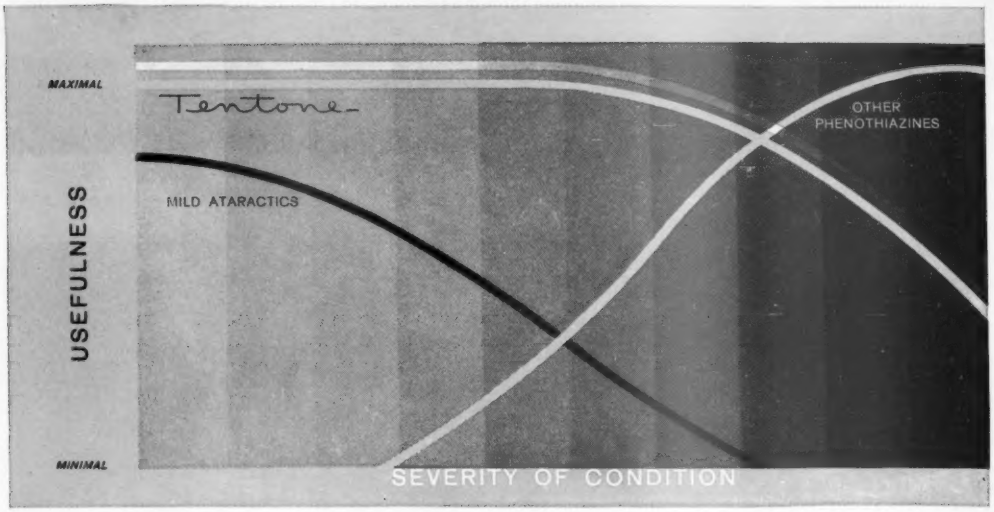
Diagrammatic cross section of eye denoting area demonstrated in Figures 1 through 5.



CLASS I
Figure 1



CLASS II
Figure 2



POSITIVE CALMING ACTION ADAPTED FOR LOWER RANGE OF EMOTIONAL DISORDERS

The development of TENTONE® Methoxypromazine Maleate *Lederle* does not duplicate primary function of existing tranquilizers. TENTONE fills the need for a practical, potent agent for extended use in everyday practice (as illustrated above).

Action of TENTONE Methoxypromazine Maleate approaches that of the strong phenothiazines without their drawbacks. Calming response is positive and rapidly apparent to both patient and physician. However, as a basic phenothiazine modification, TENTONE allows full therapeutic application in the mild and moderate range of anxiety-tension and somapsychic disorders most usually seen in general practice.

EXCELLENT TOLERATION— MARKED REDUCTION IN COMPLICATIONS

Incidence of untoward reactions is exceptionally low and approximates the mild ataractic drugs. Reduction in sensitivity reaction, intestinal distress, blood, brain or liver toxicity is striking, particularly in the low dosage range. TENTONE exhibits greater freedom from depression and drug habituation. Physical and psychic orientation is usually preserved. Occasional drowsiness may be encountered, particularly in higher dosages. In moderate to more severe cases, this sedative effect may be desired.

TENTONE has thus been described as one of the easiest tranquilizers to handle in office practice. In indicated cases, the physician may be relieved of the patient's unnecessary concern over his own illness. In contrast to the previous types of drugs, complaints over induced distress or inadequate benefit are rare.

WHEN MORE THAN MILD SEDATIVE EFFECT IS DESIRED

Consequently, TENTONE is more useful than other ataractic drugs in two areas: (1) mild to moderate conditions—when more than mild sedative effect is sought, (2) middle range of moderate to severe cases—when less than psychopathology is involved.

Indications include ■ common anxiety-tension states ■ obsessive-compulsive behavior ■ neurosis ■ depression ■ situational anxiety and hysteria

And the emotional components of: ■ agitation ■ restlessness ■ tremors ■ insomnia ■ alcohol- and drug-withdrawal syndrome ■ hyperkinesis ■ prenatal anxiety ■ rheumatic disorders ■ dermatoses ■ menopausal syndrome ■ premenstrual tension ■ peptic ulcer, other g.i. disorders ■ asthma, other allergy ■ multiple sclerosis, arteriosclerosis ■ malignancy, other progressive diseases

POSSIBLE POTENTIATION OF ANALGESICS AND NARCOTICS

Since tranquilizing drugs may potentiate the action of pain-relievers, sedatives, and barbiturates, they should be used with caution in conjunction with them, or to achieve a greater response to these drugs in various conditions when desired. They may also be useful in reduction of effective dosage to better tolerated, or non-habituating levels.

ADAPTABLE LOWER DOSAGE RANGES

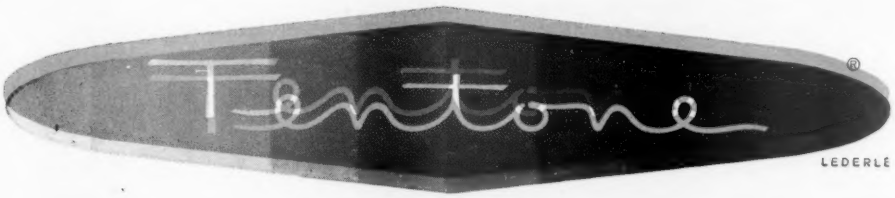
Dosage must be individualized to severity of condition and response desired.

In mild to moderate cases: varies from 30 to 100 mg. daily.

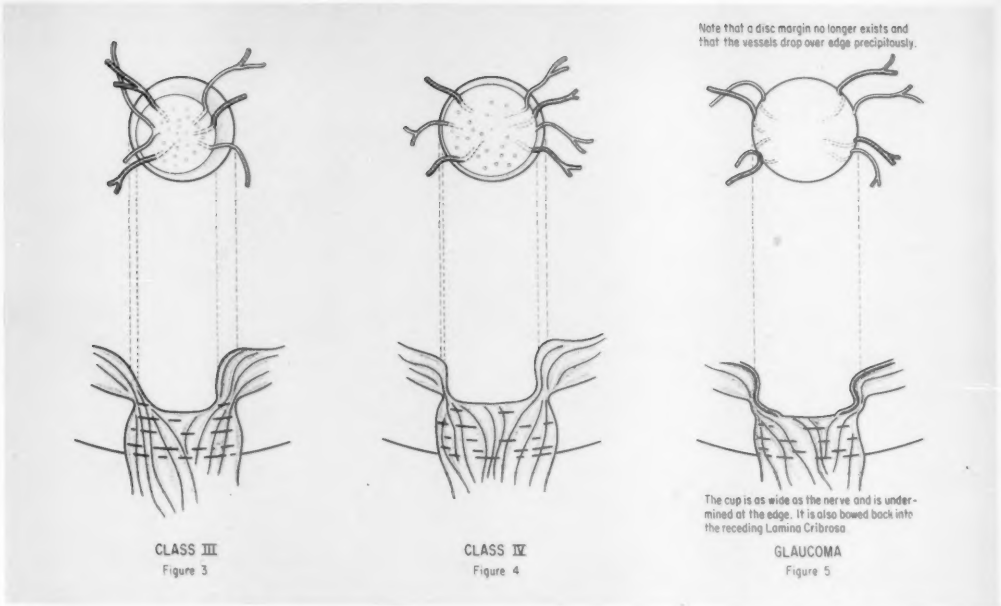
In moderate to severe cases: from 75 to 500 mg. daily.

In psychotic or institutionalized patients, TENTONE may be useful as a substitute when toxicity precludes effective dosage of other phenothiazines, or as maintenance after hospitalization. Dosage may range from 100 to 1500 mg. daily in divided doses.

Supplied: 10 mg., 25 mg. and 50 mg. tablets



Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.



CLASS III
Figure 3

CLASS IV
Figure 4

GLAUCOMA
Figure 5

Glaucoma cont. from 64

vantages over merely saying "optic nerves normal." Class I, II, or III are all normal cups, but if the patient has always had a Class I cup and then during a routine examination is found to have a Class III cup I would consider this significant. Classification also demands a more careful appraisal and I know that if I have numbered the cup that I looked at it carefully enough to evaluate it thoroughly.

The accompanying diagrammatic sketches show the four types of physiologic disks. Beneath each is a cross section of the nerve as it enters the globe. The depth of the cup if it is physiologic is not below the level of the sclera and the lamina cribrosa may be considered sclera which has been perforated by the fibers of the optic nerve. When actual glaucomatous cupping becomes late and definitive, the edges of the disk are no longer visible. The lamina cribosa, which is a weak spot in the scleral shell, is bowed backward and the edge of the disk is actually undermined as seen in Fig. 5. In order to help avoid confusion, I have not mentioned anomalies of the disk, such as colobomas or drusen. Also left out is mention of optic atrophy and papilledema. In this latter regard, however, I should like to emphasize unexpected rewards in classification of the disks, since if a patient has always been a Class II physiologic cup which enables a view of the lamina cribrosa and then becomes a Class I physiologic cup at a later date, in which the lamina is not visible, this again is obviously a valuable recorded bit of information to help rule in early choking.

This, then, is one way in which a few eyes might be saved from future blindness: the physiologic cup being studied at each annual examination and evaluated. If an enlarging cup and all Class III and Class IV cups are referred to the ophthalmologist, some of the answer, if not all, to the problem of early diagnosis of chronic simple glaucoma may be had. Remember that when the patient begins to complain of symptoms it is already too late.

Summary

Glaucoma, which simply means abnormally high ocular tension, may take many forms insofar as etiology is concerned. I do not feel that physicians not concerned with ophthalmology should be burdened with the variations of this disease. The problems of early diagnosis do not rest with the symptom producing variations. A painful eye, or one

with visual disturbances, is usually referred to an ophthalmologist forthwith. Chronic simple glaucoma, which is in truth an eye disease separate and apart from the other forms except in the sense that it shares a rise in pressure, continues to be a serious adversary. The cause of chronic simple glaucoma is as yet unknown, though effective treatment can be rendered if the condition is recognized early enough. Let us be realistic and face the fact that the means for identifying the disease are not as yet being utilized by those often in the first line of defense. A patient's history (except where positive) is not significant. Digital pressure (tactile tension) is a useless procedure which is not only uninformative but may also be misleading. I offer a method of evaluating the optic nerve on routine examination and urge that a person with a Class IV cup not be allowed to walk out of your office without obtaining consultation. Those with anything more than a Class IV cup will have to be led out. •

REFERENCES

[1]Chlost, M. R., and Horovitz, I.: Evaluation of the Berns-Tolman Hypertension Indicator, J.A.M.A. 160:661, 1956.

[2]Sugar, H. Saul: The Glaucomas, Hoeger-Harper & Co., pp. 176.

Tracheotomy in severe head injuries

Ernest W. Mack, M.D., Norman B. Smith, M.D., and Adolf Rosenauer, M.D., Reno, Nevada

An adequate airway may determine the survival and subsequent morbidity. Patients with severe head injury should not be denied this simple expedient.

"ANOXIA NOT ONLY STOPS THE MACHINE, but wrecks the machinery." (Haldane.) While it has been established that early tracheotomy is of use in other categories of injury only moderate attention has been given to its use in the early treatment of severe head injury[1-4]. Concepts gained in the treatment of severe bulbar poliomyelitis taught us that to await the arrival of the signs and symptoms of respiratory difficulty, such as cyanosis, or other signs of anoxia, for the institution of an adequate airway, namely tracheotomy, was to court disaster or failure. We considered these experiences and attempted to apply them to a group of cases which were hopeless from the prognostic and therapeutic point of view, when primarily assessed. It was thought that the same concepts might apply and that we might salvage certain cases which otherwise would most assuredly be lost. In order to do this we determined to undertake the immediate establishment of an adequate airway, particularly by the method of tracheotomy[5].

That this is not a new concept is indicated by the presentation of Dean Echols, et al., in 1950 wherein Dr. Echols concludes, as a result of studies carried out on 15 patients in whom early tracheotomy was instituted: "Tracheotomy is superior to any other method of maintaining sufficient aeration of lungs in unconscious patients. It should be performed promptly and unhesitantly in every patient unconscious from a head injury if it seems likely that the coma will persist for more than 24 hours, and if non-surgical methods of maintaining an adequate airway appear inefficient[6]." We would undertake to go one step forward in this consideration and state that it is our feeling that immediately upon admission to the hospital when the diagnosis of severe coma due to head injury has been accomplished one should consider immediately tracheotomy as one of the prime treatment methods to be undertaken. Consideration should not, of course, be taken away

from such neurosurgical procedures as may be indicated by the findings on examination of the patient. It is our feeling that adequate airway cannot be maintained for any length of time by endotracheal intubations and we would condemn its use for periods in excess of a very few hours. We would feel that if the patient's state of coma is such as to indicate the need for any type of intubation then tracheotomy should be performed.

With the increasing numbers of severe head trauma cases which are presenting themselves today with the high incidence of accident from the highways of America, it behooves us to consider any and all means which may, in some measure, help to reduce the mortality and morbidity rate which is accompanying these severe traumata. Our report is based on purely clinical observation, there not being available means of carrying out oxygen determination, CO_2 determinations, etc., such as might have been useful in being more precise in the evaluation of our data.

Having once commenced upon this type of therapy and having undertaken to do the tracheotomies ourselves, which I think is reasonably important, we were immediately impressed by the fact that in no single instance following the institution of tracheotomy in these patients did we fail to observe immediate clinical improvement in the patient's status. Even in the absence of physical findings to suggest tracheal obstruction we were at once impressed with the large amount of mucus and other materials which could be removed from the trachea, even though an endotracheal tube might have been primarily passed and the trachea suctioned prior to the surgical procedure.

It seems reasonable that a relatively simple surgical procedure, such as this is, should not be withheld from the patients whom it might materially benefit. Certainly some hazards present themselves in the use of tracheotomy. There have been reported instances of pneumothorax, bleeding, vocal cord injury[2-8]; however, these are readily avoidable and have not been encountered in our experience. In many cases actual respiratory depression of a central type may be present[1], in others, and perhaps most commonly, the anoxia is the result of actual obstruction at the nasopharyngeal level. While this may not be severe initially, it must be regarded as progressive, and when considered in its relation to other associated conditions, such as secretional accumulation, vomiting, chest or abdominal injury, the need for the most adequate airway is at once apparent. Since it is established now that severe anoxia of even a few minutes duration will bring about severe cerebral damage of its own accord, even in the absence of head trauma[9, 10], then it is not unreasonable to argue that a minor degree of anoxia in the severe head injury may contribute a like degree of damage if continued over a prolonged period of time. In this consideration, the invariable presence of fever of greater or lesser magnitude cannot be disregarded. If we accept the premise that for each degree of elevation of body temperature, oxygen requirements are increased 7 per cent[11], then even a moderate rise of 5 degrees will increase oxygen want by 35 per cent. Certain patients may be expected to fail to respond to this type of therapy; however, in our hands, the results have been so gratifying as to dictate that tracheotomy is a prime consideration in the treatment of this group of cases.

CASE REPORTS

C.K., aged 19, white female. This girl was admitted to the hospital following a head-on collision in which she had struck her forehead severely on the dashboard. She had suffered a fracture of the jaw, fracture of the medial epicondyle of the left humerus, multiple contusions and abrasions and a severe cerebral concussion and contusion. She also had spells of severe anoxia, the reason for which was a denture lying in the right mainstem bronchus. There was deep coma with spasticity of the lower extremities, non-reactive small pupils, areflexia, bilateral Babinski sign. A tracheotomy was performed on admission and 24 hours later a bilateral temporo-frontal trephination with drainage of subdural effusions was performed. After about three weeks of stormy course, complicated by a partial collapse of the left lower lobe of the lung, the patient regained consciousness on the twenty-first day after injury and was discharged two weeks after that. She has recovered to the extent of returning to school. The tracheotomy wound was allowed to close on the twenty-third day after injury.

R.W., aged 25, white male. The patient was admitted shortly after his automobile had crashed into a stationary object. On admission he was in deep coma. There were Cheyne-Stokes respira-

tions, there was a large ecchymosis about the right orbit, multiple lacerations about the face, dried up blood in the mouth and nose. There was a conjugate eye deviation to the left and the pupils were non-reactive, pulse and blood pressure were at shock levels, there was a left-sided Babinski. Tracheotomy was carried out immediately and bilateral temporo-frontal trephination and exploration was negative. The hospital course was complicated by spells of decerebrate rigidity and persistent copious secretions from the chest. He recovered to the point of stable vital signs and consciousness without any evidence of returning intelligent vitality. His tracheotomy was in place for 50 days and the patient was transferred to another hospital with it. Eight months following this transfer the patient had regained mental ability to the level of saying a few words and executing simple commands.

A.R., aged 33, white male. Admitted in coma shortly after an automobile accident. There was moderate restlessness, resistiveness to painful stimulation, multiple lacerations and contusions. There was blood in both nares, respirations were snoring and stertorous, and there was a bilateral Babinski sign. Tracheotomy was carried out immediately with considerable improvement in the respiratory status. Several days afterwards a bilateral temporo-frontal trephination was productive of bilateral subdural effusions. Total days of coma were six, tracheotomy was allowed to close after 12 days. Recovery, six months after injury, was satisfactory with only a slight residual of pyramidal signs.

M.B.T., aged 20, white female. This patient was admitted in deep unconsciousness after an automobile accident. There were multiple abrasions and contusions, dilatation of the left pupil without any reaction of either pupil, bleeding was noted from the right auditory canal, all extremities were spastic, reflexes hyperactive and there was a bilateral Babinski and clonus. A tracheotomy was carried out, as well as bilateral trephinations which were productive of a large left subdural effusion. Period of coma was 17 days, tracheotomy was in place for a total of 30 days. Neurologic residual at discharge was limited to a left facial paresis, upper motor neuron, and weakness and spasticity of the left arm and to a lesser extent of the left leg, with left-sided pyramidal signs. She was, however, able to return to her housework.

A.S., aged 39, white male. Automobile accident approximately two hours prior to admission. There was deep coma, shock from blood loss, multiple lacerations and contusions, right sterno-clavicular separation, separation of symphysis pubis, spastic extremities and right Babinski. There were spells of decerebrate rigidity. The bladder was ruptured and a suprapubic cystotomy had to be performed followed by a tracheotomy, and on the eleventh day a bilateral temporo-frontal trephination showed bilateral subdural effusion. Recovery was very protracted and the patient was discharged eight months after the injury, severely crippled mentally and physically.

J.H., aged 40, white male. Automobile accident. Patient was in deep coma on admission with all extremities flaccid, there were multiple abrasions, a laceration above the right eye with ecchymosis, and pupillary inequality. Pulse and blood pressure were at shock levels, there was a left Babinski. Tracheotomy was done 24 hours after admission and a considerable amount of muco-purulent material was aspirated from the chest. Four days after that bilateral trephination revealed a subdural hematoma on the right. Recovery was complicated by massive edema of the neck and lower portions of the face and spells of respiratory embarassment. His coma lasted 14 days after which time the patient was transferred to another hospital with the tracheotomy tube in place. Nine months after injury his recovery had gone to the level of the patient being able to talk coherently, walk about, and handle himself reasonably well.

L.B., aged 16, white male. Admitted unconscious after an automobile accident. There was a compound skull fracture, multiple scalp lacerations, cerebral-spinal rhinorrhea, compound fracture of the right elbow. On the day following admission there was respiratory embarassment and a tracheotomy was performed immediately with consequent improvement. Three days afterward bilateral temporo-frontal trephination showed a small right subdural effusion. Total period of coma was 10 days, tracheotomy was in place for 27 days. Recovery went to the point where the patient was able to return to school and to perform the usual duties of a student.

G.S., aged 52, white male. In deep coma from an automobile accident. There was a massive contusion over the right fronto-parietal area, a conjugate eye deviation to the left and a right Babinski. On the day of admission tracheotomy was carried out and bilateral temporo-frontal trephination showed a bilateral subdural effusion. During his postoperative course the patient bled repeatedly from scalp veins, from a small branch of the superficial temporal artery and finally from arteries from the surface of the brain until he expired on the eighteenth day after injury without having regained consciousness.

F.R., aged 51, white male. This patient was injured when struck by a cow and thrown against a wall. There was aphasia, semi-consciousness, bleeding from nose and mouth, pupillary inequality, variable right Babinski. On the fifth day tracheotomy was done and bilateral temporo-frontal trephination productive of a small left subdural hematoma. His recovery was marked by copious amounts of tracheobronchial secretion which he had been unable to clear before. The postoperative course was complicated by a pre-existing diabetes as well as beginning alcoholic liver cirrhosis. He expired on the ninth day following injury.

J.A., aged 54, white male. Admitted with external cranial trauma leading to coma. Although his blood pressure was normal, pulse rate was approximately 120 and his respiration was stertorous. Pupils were non-reactive and the patient was incontinent of bowel and bladder. There was grossly bloody spinal fluid. X-rays showed an L-shaped fracture of the left posterior temporal-parietal area and upon trephination a left subdural hematoma was encountered. A tracheotomy was carried out 24 hours after admission. The patient expired six days after injury.

V.T., aged 20, white female. Admitted in coma after an automobile accident. Tracheotomy was instituted immediately and a right thoracentesis was performed. Splenectomy was necessitated. On the eighth day bilateral trephination was carried out showing moderate subdural collections of yellow fluid. Consciousness returned on the fourteenth day.

J.G., aged 19, white male. Admitted in deep coma shortly after automobile accident. Skull x-rays showed a basiliar fracture extending into the vicinity of the foramen magnum. Pupils were dilated and fixed. Tracheotomy was performed immediately. Total survival time, seven hours.

D.H., aged 20, white male. Admitted in deep coma after having been run over by a fire engine. Multiple compound skull fractures. Tracheotomy performed immediately. Total survival time, three hours.

D.T., aged 33, white male. Admitted in coma after having been struck by a falling steel boom. There were extensive scalp hematomata and lacerations, both eyes swollen shut and a fracture of the skull to the right of the sagittal suture extending into the right orbit. Tracheotomy was performed immediately and the scalp lacerations sutured. Total survival time, three hours.

T.L., aged 44, white male. The patient admitted in coma several hours after having been arrested subsequent to a fight. He had multiple abrasions and contusions and a dilated right pupil. There was profuse mucus in the throat and gargling respirations, urinary incontinence. Tracheotomy was performed immediately and also bilateral temporo-frontal trephination, which showed a right subdural hematoma. Although patient's vital signs stabilized he remained comatose until he expired on the twentieth day following admission. Autopsy showed a central pontine hemorrhage.

J.McG., aged 65, white male. Admitted in coma after being struck by automobile. Respirations moist and stertorous, multiple abrasions and contusions, and a laceration 10 cms. in length over the vertex of the skull with diffuse hematoma, bilateral bloody otorrhea and fixed non-reactive pupils, compound fracture of the right lower leg, blood pressure and pulse rate at shock levels. Comminuted fracture of the left parietal area with depression. Tracheotomy was performed immediately. Total survival time, three hours.

H.B., aged 59, white male. Admitted in deep coma after automobile accident with lacerations of the scalp, on the left arm and back and a deep compound, depressed fracture in the right frontal area. Dilated non-reactive right pupil, palpable rib fractures. Tracheotomy was done on admission. Total survival time, three days.

Discussion

Review of the summaries of these cases indicates that in all cases the severity of symptomatology on presentation at hospital was such as to indicate a negative prognosis, for the most part. Certainly, in most of these cases, if not all, without the institution of tracheotomy a fatal outcome might have been expected although noted neurosurgical procedures which were indicated in the various cases contributed materially to their survival and improvement, and in some cases must be considered to be lifesaving. However, these neurosurgical procedures could not have achieved the desired result without maintenance of complete and satisfactory airway, such as was possible to accomplish through the use of tracheotomy. It is notable that in the cases where there was failure of survival severe complicating factors were present, which contributed, in some measure, to the failure of accomplishing the desired effect and this, of course, must be expected. In addition to this, one must realize on undertaking this type of therapy in a group of patients such as this that he may expect to accomplish a satisfactory result from a physical standpoint and in some instances be confronted, upon completion of the case, with a mental or emotional cripple of such severity as to require institutional care for the duration of life. This, I feel, we must all accept as not something which can be prognosticated when one undertakes to treat such a case.

In conclusion, I should like to reiterate that if success is to be accomplished in the handling of the severe head injury case, such as has been presented in this group, then radical means of treatment must be utilized and the prime consideration in this line is the use of immediate tracheotomy. I feel that it is an error in judgment to await the indications of the need for a better airway in this type of case if one hopes to have any reasonable survival rate and to carry out, in every way possible, the necessary measures to decrease morbidity. •

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Carcinoma of the bladder—problems in management*

Hugh J. Jewett, M.D., Baltimore, Maryland

Radical resection is not always the best answer when the diagnosis has been made. Practical solutions are necessary. The family physician is still the key to early diagnosis.

EPITHELIAL TUMORS OF THE URINARY BLADDER begin in one of two ways: either as a small villous, pedunculated outgrowth from the mucosa and submucosa, which is called a papilloma, or as a slightly thickened reddish patch of roughened mucosa resembling coarse sandpaper, referred to as non-invasive sessile carcinoma, or carcinoma-in-situ. Both types sooner or later increase in bulk, invade the wall of the bladder and metastasize.

As invasion of the bladder wall progresses the therapeutic difficulties become more complex. It is obvious that cure will depend on complete elimination of all cancer cells. These cells therefore must still be confined to the wall of the bladder, for if any have passed through and escaped from it by direct extension to neighboring structures or by lymphatic or venous transportation, cure will be virtually impossible.

There are four principal problems involved in the successful management of bladder cancer. The first three confront the urologist and shall be mentioned in order to clarify for you his concept of this disease and the nature of the task he faces. The fourth, and possibly the most important problem concerns the family physician.

The problems of the urologist would be greatly simplified if he were willing to perform total cystectomy in all cases in which he can identify neoplastic infiltration into the bladder wall. Then there would be no need for painstaking and meticulous classification, and no fear that his carefully selected operation might in the long run prove to have been too conservative. Survival figures, however, suggest that routine total cystectomy is not the final and simple solution to the problem. Moreover, the bladder is not readily expendable. It is a useful organ, and one parts with it only with the greatest reluctance. Although improved methods of urinary diversion have succeeded in making life after cystectomy tolerable, living under such circumstances is not exactly normal. The patient either has some apparatus to cope with or faces the ever-present threat of electrolyte imbalance, hydronephrosis and ascending renal infection. In the male impotence is a common sequel.

Because of these and possibly still other reasons, most urologists prefer to employ conservative treatment if there is convincing evidence that such treatment will suffice. The crux of the matter, therefore, concerns this evidence, which must provide the indication that the tumor is still completely confined to the bladder wall and can be eliminated therefrom either by excision or by radiation without rendering the bladder a useless, painful or incompetent organ. Experience has shown that certain gross and microscopic characteristics of the primary tumor, when

*From the James Buchanan Brady Urological Institute, The Johns Hopkins Hospital, Baltimore, Maryland.

TABLE 1

Relation of curability to depth of infiltration in 107 autopsy cases

	Infiltrating Carcinoma of Bladder		
	Group A (Submucosa)	Group B (Musculature)	Group C (Perivesical fat)
Number of cases	3	15	89
Metastases	0	1	52
Perivesical lymphatic invasion only	0	1	6
Perivesical fixation only	0	0	8
Potentially curable	3	13	23

properly evaluated, are capable of furnishing this evidence in a surprisingly high percentage of cases. This naturally implies a precise preoperative classification, which poses the first problem in urologic management.

In 1922 Broders showed that tumors could be divided into four groups, corresponding to four possible degrees of deviation of the cells from normal epithelium. His classification, indicating four different grades of malignancy, stressed the importance of the lack of cellular differentiation within a tumor. The least differentiated tumors were the most malignant and were graded four. In general, the prognosis is much worse in this group, but sometimes such cases are small and superficial and are readily cured by conservative procedures.

In 1944 a study of autopsy material at the Johns Hopkins Hospital showed that the depth to which the tumor had invaded the bladder wall was also of considerable prognostic significance (Table 1). Metastases were rare when the tumor was superficial, and frequent when it was deep[1].

To see whether the extent of infiltration by the tumor was merely a manifestation of its degree of malignancy a correlation was made between histopathology and depth of penetration[2]. In the deep group 60 per cent of the tumors had recognized metastases. In this group metastases were present in 50 per cent of those that were moderately well differentiated and in 68 per cent of those that were poorly differentiated or undifferentiated (Table 2).

In the rather small group of 14 superficially infiltrating tumors only one had metastasized. This was one of six poorly differentiated tumors, or 17 per cent (Table 3). Tumors of a high grade of malignancy had metastasized four times as often when deep as when superficial. Tumors of a medium grade of malignancy had metastasized in 50 per cent of the cases that were deep, and in none of the cases that were superficial. There-

TABLE 2

Histologic Classification of 81 Tumors in Group C

	Primary Tumor	Metastases
Papillary carcinoma	28	11
Epidermoid carcinoma	35	22
Undifferentiated carcinoma	18	15

In the papillary group 13 tumors were poorly differentiated, and five of these had metastasized. In the epidermoid group there were 22 cases in which the tumors were poorly differentiated, and of these 16 had metastasized.

TABLE 3

Histologic Classification of 14 Tumors in Group B

	Primary Tumor	Metastases
Papillary carcinoma	10	1
Epidermoid carcinoma	4	0
Undifferentiated carcinoma	0	0

In the papillary group four tumors were poorly differentiated, and one of these had metastasized.

In the epidermoid group two were poorly differentiated, and neither had metastasized.

TABLE 4

Relation of depth of infiltration of carcinoma of bladder to five-year survival rate after complete extirpation

Depth of Infiltration	No. of Patients	No. Living 5-14 Yrs. Without Tumor
Submucosal (group A)	14	10
Superficial muscular (group B_1)*	5	4
Total superficial infiltration	19	14
Deep muscular (group B_2)†	13	1
Perivesical (group C)	48	1
Total deep infiltration	61	2

*Group B_1 represents infiltration less than halfway through the muscularis.

†Group B_2 represents infiltration halfway or more through the muscularis.

fore, on the basis of cellular characteristics alone one could not have predicted with much consistency the presence or absence of metastases.

The cellular appearance of a bladder tumor, however, seems to indicate in a general way its "speed." The higher the grade of malignancy the faster it penetrates the bladder wall. This explains why most grade four tumors have reached the perivesical fat by the time the clinical examination is finally made. This, however, is not always the case, and some of these tumors are still superficial. One therefore cannot predict from grade alone just how far penetration has progressed.

This study of autopsy cases yielded valuable information regarding potential curability in general, but the facts obtained did not indicate whether an anatomic dividing line could be drawn in the bladder wall between localized and non-localized tumors. As a preliminary venture, 80 clinical cases, subjected to complete surgical extirpation of the primary growth more than five years previously, were separated into four stages of infiltration[3]. An arbitrary dividing line between superficial and deep tumors was placed at the halfway level in the muscle wall. In the superficial group 14 of 19 patients lived five to 14 years without recurrence, and in the deep group only two of 61 patients lived five years (Table 4). The tumor was of high grade malignancy in 37 per cent of the patients who survived five years, and in 54 per cent of those who succumbed to their disease. This clinical study gave additional evidence that grade of malignancy is not the only, or even the most important, criterion of potential curability.

The clinical preoperative classification therefore entails a careful estimate of the depth of penetration as well as the microscopic characteristics of the tumor. Bimanual palpation of the bladder under anesthesia reveals the presence or absence of obvious tumor mass. In all cases in which the tumor

TABLE 5

Bimanual Examination	Depth of Infiltration	Prospect for Cure
No thickening; no mass	Submucosal or superficial muscular (see biopsy)	Good
Thickening; no mass	Submucosal or superficial muscular (see biopsy)	Good
Mass, rubbery consistency, movable. Lateral ligaments negative	Deep muscular or perivesical (if not large papilloma; see biopsy)	Poor
Mass, stony consistency, movable. Lateral ligaments negative	Perivesical	Poor
Mass, stony consistency, movable. Ligament thickened and indurated	Perivesical	Very poor
Mass, stony consistency, fixed	Perivesical	Very poor

Jewett, H. J., in chapter on Neoplasms of Bladder, The Cyclopedia of Medicine, Surgery, Specialties; Philadelphia, F. A. Davis Company, 1950.

TABLE 6

Classificiation of primary tumors of the urinary bladder

Level of Bladder Wall	Maximum Depth of Infiltration (Stage)	Histologic Pattern						
		Grade of malignancy						
		Low grade (1-2)		High grade (3-4)			Adeno-carci-noma	Miscel-laneous
		Trans. cell (pap-illary)	Epider-moid (squa-mous)	Trans. cell	Epi-derm.	Undiff. (ana-plastic)		
Mucosa	O							
Submucosa	A							
Superficial muscle	B_1							
Deep muscle	B_2							
Perivesical fat	C							

is readily palpable the infiltration is deep, provided that what is felt is within the wall, and not just projecting into the cavity of the bladder[4]. In cases in which no mass can be felt, sections of the bladder wall taken with the resectoscope at different depths beneath the tumor will give a reasonably good indication of the extent of penetration (Table 5). At present it seems that the halfway level within the muscle of the bladder wall is a fairly reliable dividing line between superficial, or localized, and deep, or non-localized, tumors.

Table 6 represents a useful and desirable classification, combining stage of infiltration with the cellular characteristics of the tumor. By putting any given tumor as accurately as possible into its proper position in this table, one can see at a glance how much of a procedure the situation demands. It prevents us from doing too much or too little, and it enables us to evaluate the efficacy of different procedures in the case of identical tumors.

The second problem in management concerns the selection of a specific type of treatment for the case in question. But before one can make a rational choice one must know the limitations of each available procedure when applied to cases exhibiting all the characteristics of the present tumor. It will take some time before all these facts are known, but a good start already has been made. Table 7 illustrates the survival rates reported by different authors using different excisional technics for tumors classified in regard to depth of infiltration. Already one

TABLE 7

Five-year survival rates after surgical treatment of infiltrating carcinoma

(Milner's cases, presumed cured, were not all followed five years. Whitmore's and Marshall's cases of radical cystectomy were followed four years.)

Depth of Infiltration	Electro-excision		Segmental Resection	Simple Cystectomy	Radical Cystectomy
Superficial (Stage O, A, B_1)	82.6% (low grade) (A)	Nichols[5]	62.5% Marshall[8]	36.8% Brice[9]	39% (4 years) Whitmore and Marshall[10]
	76.5% (high grade) (A)	Nichols	70 % B.U.I.	50 % B.U.I.	
	70 % (A)	Milner[6]			
	57 % (B_1)	Milner			
	56 % (B_1)	Flocks[7]			
Deep (Stage B_2, C, D)	15 % (includes B_1)	Nichols	22 % Marshall	10.9% Brice	11% (4 years) Whitmore and Marshall
	23 % (B_2)	Milner	8.3 % B.U.I.	9 % B.U.I.	
	3 % (B_2)	Flocks			
	7 % (C)	Milner			

can see that radical cystectomy is not the final answer to the problem of therapy. The simpler procedures have given the best results whenever they have been applicable. At the present time sufficient information has not been accumulated to enable us to compare the results of different types of radiation with those provided by different excisional technics in accurately classified cases.

The third problem in management is concerned with individual preferences arising from differences in technical skill. A person with great proficiency in transurethral surgery may obtain a better result by a closed operation than he could possibly obtain by open surgery, even though the figures may suggest that the open operation is the better procedure for the case in question. The choice of treatment under such circumstances had best be left to the discretion of the urologist.

The three problems in management enumerated above are those that confront the urologist. They consist of classification, appraisal of technics, and application of that which seems most appropriate in relation to personal proficiency. He proceeds step by step in a logical manner to arrive at a rational solution, but when the tumor is deep his best efforts usually end in failure. The fourth problem concerns the family physician, who often holds the key to the patient's ultimate survival.

Presenting symptom

The physician knows that blood in the urine is the presenting symptom in approximately 80 per cent of the cases, and that it may be transient or persistent, scanty or profuse, and that, often painless, its quantity bears no constant relation to the gravity of the situation. He also knows that frequency, sometimes with pain, is present is over 30 per cent of the cases. The physician is also fully aware that early, small, and superficial tumors can be destroyed with ease, and that these if neglected become extensively infiltrating cancers which are rarely curable. What then is the reason for the predominance of these large incurable cancers in most urologic clinics?

In the first place the cardinal symptoms of hematuria and vesical irritability may occur late, or they may be too slight to disturb the patient. It does not seem possible to him that such minimal changes in his urinary function could signify serious trouble. Secondly, many conditions other than cancer can cause hematuria and frequency. The physician therefore may yield to the temptation to temporize, and, if the hematuria spontaneously disappears, he may feel that his judgment has been vindicated. It is well to remember, however, that bladder cancer afflicts 17 persons in 100,000 in the general population between 40 and 75 years of age.

Physician aid

What now should be emphasized is the urgent need of immediate definitive diagnosis in all cases of gross or microscopic hematuria, unless there is some compelling contraindication. Recognition of this need is the problem of the family physician in the management of this disease. He sees the patient first, and knows there are red cells in the urine. The patient may be comfortable and unimpressed with the findings, and disinclined to submit to detailed investigation. The physician, aware of the possibilities, may feel inconsistent first in attempting to reassure him and then in insisting on immediate urography and cystoscopy. His task is often difficult, but his persuasion is a vitally important step in the long chain of events that finally result in cure. The urologic record has improved in the last 20 years, but probably will not improve much more without the wholehearted and aggressive cooperation of the family physician. It is his help which we now urgently need. •

REFERENCES

[1]Jewett, H. J., and Strong, G. H.: Infiltrating Carcinoma of the Bladder; Relation of Depth of Penetration of the Bladder Wall to Incidence of Local Extension and Metastases. J. Urol., 55:366-372, 1946.

[2]Jewett, H. J.: Infiltrating Carcinoma of the Bladder; Application of Pathologic Observations to Clinical Diagnosis and Prognosis. J.A.M.A., 134:496-500, June 7, 1947.

[3]Jewett, H. J.: Carcinoma of the Bladder; Influence of Infiltration on the Five-Year Results Following Complete Extirpation of the Primary Growth. J. Urol., 67:672-676, 1952.

[4]Jewett, H. J.: Carcinoma of the Bladder; Treatment and Prognosis. South. M. J., 43:661-667, 1950.

[5]Nichols, J. A., and Marshall, V. F.: The Treatment of Bladder Carcinoma by Local Excision and Fulguration. Cancer, 9:559-565, 1956.

[6]Milner, W. A.: The Role of Conservative Surgery in the Treatment of Bladder Tumors. Brit. J. Urol., 26:375-384, 1954.

[7]Flocks, R. H.: (Discussion in symposium on bladder tumors). J. Urol., 67:680, 1952.

[8]Marshall, V. F., Holden, J., and Ma, K. T.: Survival of Patients with Bladder Carcinoma Treated by Segmental Resection. Cancer, 9:568-571, 1956.

[9]Brice, M., II, Marshall, V. F., Green, J. L., and Whitmore, W. F., Jr.: Cancer, 9:576-584, 1956.

[10]Whitmore, W. F., Jr., and Marshall, V. F.: Radical Surgery for Carcinoma of the Urinary Bladder. Cancer, 9:596-608, 1956.

RADIOLOGIC REFLECTIONS

Shadow or substance

Marcus J. Smith, M.D., Santa Fe, New Mexico

Apothegm

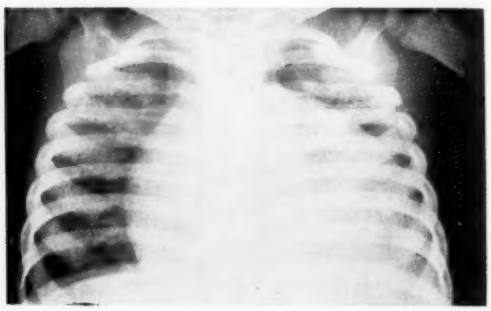
"It is my opinion to have no opinion." (Timocles of Clos).

Clinical data

A 2-year-old boy of French, Dutch and Spanish descent had exhibited vomiting, anorexia and shortness of breath for three months. A sibling had died at 21 months of age with supposedly similar symptoms. There was a family history of tuberculosis. On examination, the child was noted to be acutely ill and in distress. There was obvious lymph node enlargement in both sides of the neck. The liver and spleen were also enlarged. Cardiac murmurs were heard.

X-ray studies

A film of the chest showed massive cardiac enlargement; the left border bulged prominently and the apex almost reached the lateral chest wall. The aortic knob was not discernible; the vascular markings appeared normal. A diagnosis was not offered on this single study, but additional examinations were recommended including fluoroscopy and the use of contrast agents.



Laboratory data

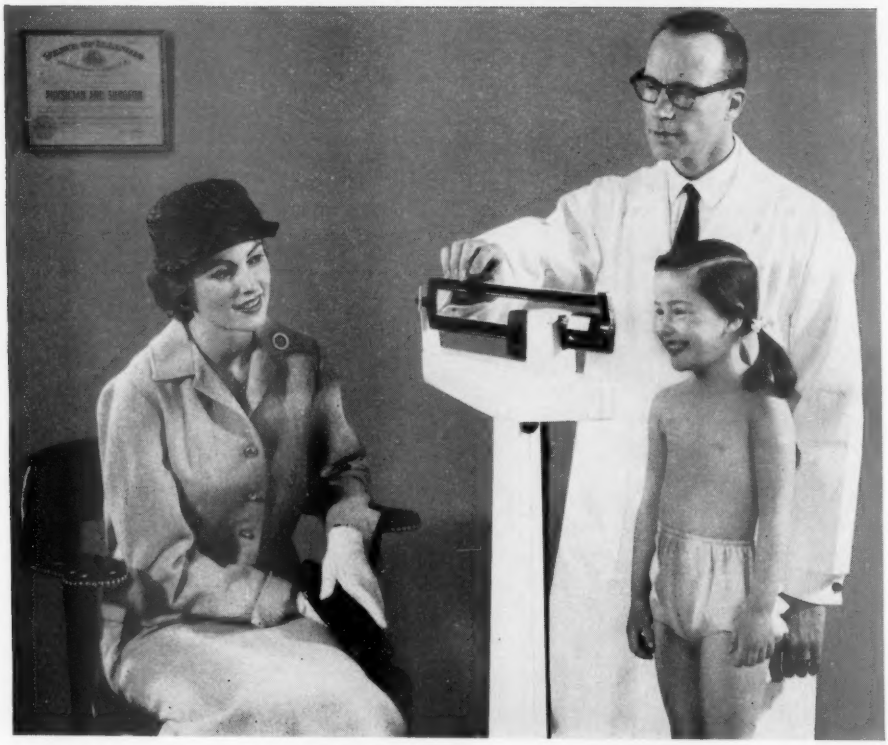
Peripheral blood studies disclosed a hemoglobin content of 1.8 gms. per cent, and there were only 1,300,000 red blood cells per cu. mm. There was marked poikilocytosis, anisocytosis, achromia, occasional target forms, and 3-5 normoblasts per 100 white cells. Rare immature myeloid cells were present. Bone marrow studies did not suggest a leukemic state. The total proteins were 3 gms. per cent, the albumin was 0.6 gms. per cent and the globulin 2.4 gms. per cent. The icterus index was 23 units.

Clinical course

The patient responded satisfactorily to transfusions and anti-anemic therapy. He was followed for nine years; no relapse occurred and no further transfusions were necessary. Retrospectively, this was probably an acute hemolytic anemia of undetermined pathogenesis, recalling the type reported by Lederer.

Epicrisis

A diagnostic radiologist must avoid speculation when his data are notably insufficient. A speculative *diagnosis*, if made from this single film, might have been misleading in that congenital heart disease would have been considered, while all that was actually observed was a striking cardiac dilatation subsequently found to have been caused by the severe anemia. The heart returned to normal size and the murmurs disappeared with the clinical improvement.



Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

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*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

The overriding health issue here—and one of the more debated subjects in any field—has been the dispute over radiation health hazards.

Out of the controversy, it is clear, will come a sharply stepped-up federal program of evaluating radiation levels, testing foods, and determining the effects of radiation on the human body.

Already, Arthur S. Flemming, Secretary of Health, Education and Welfare, has called for such an expanded program. And key Congressmen are even more insistent that the government do more work in this area.

The growing concern over radiation levels and their effect on health has prompted harsh criticism of the Atomic Energy Commission by some lawmakers who contend the agency is minimizing radiation dangers because it handles the testing of nuclear bombs.

Agency officials claim they have held back no information from the public, but they agree on the need for a government-wide survey of the entire problem to determine how it might best be handled. At present, the AEC does the bulk of the research work on the biological effects of radiation.

The AEC and the Public Health Service have reported that the amounts of radioactive strontium-90—the isotope that is released into the atmosphere by hydrogen bomb shots—have been far below estimated danger levels in food that has been tested.

However, Mr. Flemming has conceded that much more research has to be done. For example, he pointed out, little is known now about how much strontium-90 is retained within the body, though the amount consumed can be gauged.

A special advisory committee of 12 scientists and physicans that was appointed by the Health Service recommended after a year's study an exhaustive program of radiation research and protection as well as shifting prime responsibility from the AEC to the Health Service. The advisory group, headed by Dr. Russell H. Morgan of Johns Hopkins University, proposed also some sort of federal supervision over x-ray machines used by physicians.

Chairman Lister Hill (D., Ala.) of the Senate Labor and Public Welfare Committee has introduced legislation to carry out the advisory group's

continued on 83

recommendations, and called for hearings on the measure.

Meanwhile, the National Academy of Sciences, with the backing of the Administration, has undertaken a broad new investigation of the biological effects of radiation.

Notes

The House overwhelmingly approved the Keogh-Simpson measure to encourage retirement plans for the self-employed. Sen. Harry F. Byrd (D., Va.), chairman of the Senate Finance Committee, promptly announced that he would hold hearings on the legislation this session. Last year, the Senate Finance Committee was unable to hold hearings on the measure since it passed the House too late in the session.

Rep. Aime J. Forand (D., R. I.) admitted that the future of his bill to provide government medical and hospital care as part of the Social Security program is dark.

In a report to Congress, the American Medical Association noted "solid progress" in its program to improve the health care of the aged. Dr. Leonard W. Larson, chairman of A.M.A.'s Board of Trustees, said in a letter to the House Ways and Means Committee that the development of new insurance programs and expansion of existing lower cost protection for the elderly are moving forward "even faster than many of us would have dared hope only a few months ago."

The Defense Department's handling of the Medicare program providing treatment in civilian hospitals for qualified dependents of military personnel came in for some new Congressional criticism. In a report accompanying an emergency money measure, the House Appropriations Committee said it was concerned with the "high costs" and believes "that little or no effort" has been made to obtain reasonable rates for fees and expenses."

"It's nothing serious—He's just allergic to house dust."

Guest Speakers ▷

WYOMING

FIFTY-SIXTH ANNUAL MEETING

Wyoming State Medical Society

JACKSON LAKE LODGE, MORAN, WYOMING, JUNE 11, 12, 13, 1959

Official call

To the Officers, Delegates, Committeemen and Members of The Wyoming State Medical Society, Greetings:

The Fifty-sixth Annual Meeting of The Wyoming State Medical Society will be held at Jackson Lake Lodge, Moran, Wyoming, Thursday through Saturday, June 11, 12, 13, 1959.

The House of Delegates will convene at 9:00 a.m., Friday, June 12, as shown in this program, and subsequently as ordered by it.

The General Scientific Assembly will convene at 3:00 p.m., Thursday, June 11, and subsequently according to the program of the Scientific Program Committee.

L. Harmon Wilmoth, M.D.,
President

General information

The scientific meetings will be held in the meeting room directly below the Jackson Lake Lodge Auditorium. All doctors' wives and members of the "Auxiliary" are cordially invited to attend any and all of the scientific sessions.

Registration fee, $25.00.

The registration fee is required of all doctors except out-of-state guest speakers. Medical students properly certified by their dean and professional men and women allied with medicine are welcome to register and attend the scientific sessions and exhibits without fee.

All Doctors of Medicine, regardless of residence or membership in any medical society, are welcome to register and attend the scientific sessions and social functions of the Society.

Registration. Every person who attends must first register at the Society's registration desk at the Lodge. Admission (including the stag party) is by registration badge only.

Sessions on time!

Courtesy to Speakers:

We urge you not to affront our speakers by distracting them and their audience by straggling in late or leaving the sessions early. For this reason we in Wyoming hold it an inviolable rule to begin papers and discussions exactly as scheduled. Everyone on the program is held exactly to the allotted time.

Council meetings

Please note that the Council is meeting at 1:30 p.m., Thursday, June 11, 1959. The Council will again meet at 5:00 p.m., Saturday, June 13, 1959.

House of Delegates

Only the officers and delegates officially elected by the County Societies may vote, but all other members of the Society are entitled to attend the regular meetings of the House of Delegates.

Members of the Society should therefore plan to attend these meetings and get the answers to questions about Society progress, the public relations and educational programs, and the other activities which operate as a result of your membership and your dues dollar. Please check the meeting times in the General Program.

Orientation program

For new members of The Wyoming State Medical Society, an Orientation Program is planned for your convenience from 9:00 a.m., Friday, June 12, until 12:00 noon. This meeting will meet concurrently while the House of Delegates is meeting. This meeting will be held in the Auditorium or in one of the smaller rooms just west off the Auditorium.

Tickets

Tickets for all functions will be available at the registration desk in the Lodge.

Ralph C. Benson, M.D., Professor of Obstetrics and Gynecology, University of Oregon School of Medicine, Portland

Edward Harper Rynearson, M.D., Mayo Clinic, Rochester, Minnesota

John M. Salyer, Colonel, M.C., Fitzsimons Army Hospital, Denver

Ralph M. Stuck, M.D., Neuro-surgeon, Denver

PROGRAM

Thursday, June 11

Morning

Presiding—Robert Bowden, M.D., Chairman, Fee Schedule Committee.

10:00—Wyoming State Medical Society Fee Schedule Committee Meeting, Wort Hotel, Jackson, Wyoming.

12:00—Registration, Lobby, Jackson Lake Lodge.

Afternoon

1:30 to 2:30—Council meeting.

3:00 to 3:30—Recess to view exhibits.

SCIENTIFIC MEETING

Presiding—H. P. Caraway, M.D., President, Montana Medical Association.

3:30—A State Medical Examiners System, Alan R. Moritz, M.D.

4:00—Constrictive Pericarditis, Charles H. Scheifley, M.D.

4:30—Experiences With 100 Direct Vision Open Heart Procedures Utilizing Artificial Heart-Lung Machine, John Salyer, Colonel, M.C.

5:00—Nominating Committee, Benjamin Gitlitz, M.D., Chairman. Same room as Scientific Meeting.

5:30—Credentials Committee, S. J. Giovale, M.D., Chairman. Same room as Scientific Meeting.

Evening

6:30 to 7:30—Cocktail Party — Doctors, Wives, Guests and Detail Men—Sun Deck.

7:30—Stag Party—Doctors, Guests and Detail Men —Explorers Room.

Friday, June 12

Morning

8:30—Movie, Jerome H. Kay, M.D.—Explorers Room. Open-Heart Surgery Using the Kay-Anderson Heart-Lung Machine.

9:00 to 12:00—House of Delegates Meeting.

ORIENTATION PROGRAM

For Doctors entering the state in the past two years.

Presiding — Benjamin Gitlitz, M.D., President-Elect.

9:00—Call to Order.

9:05—Address of Welcome, L. Harmon Wilmoth, M.D., President.

9:15—How the State Society Operates. Some Facts About Our Blue Shield, Arthur R. Abbey.

9:45—Medical Legal Affairs, Franklin D. Yoder, M.D.

10:00—What the A.M.A. Means to You, William Thaler, M.D.

10:15—Recess and Questions.

10:45—The Doctor as a Witness, Byron Hirst.

11:00—Public Relations, Charles Moore.

11:15—Civil Defense, George H. Phelps, M.D.

11:30—Mutual Funds in an Investment Program, Don C. Fields.

11:45—Questions.

12:15—Adjournment.

12:30—Luncheon—None Scheduled.

Afternoon

Presiding—John I. Zarit, M.D., President, Colorado State Medical Society.

1:30—Significance of Lumps in the Neck, H. Mason Morfit, M.D.

2:00—Chest Pain, Charles Scheifly, M.D.

2:30—The Many Masquerades of Murder, Alan R. Mortiz, M.D.

3:00—Recess to view exhibits.

3:30—Some Aspects of the Solitary Pulmonary Nodule, John Salyer, Colonel, M.C.

4:00—Medical and Surgical Problems of the Anterior Pituitary, Edward H. Rynearson, M.D.

4:30—(Not Announced.) Edgar J. Poth, M.D.

5:00—Adjourn.

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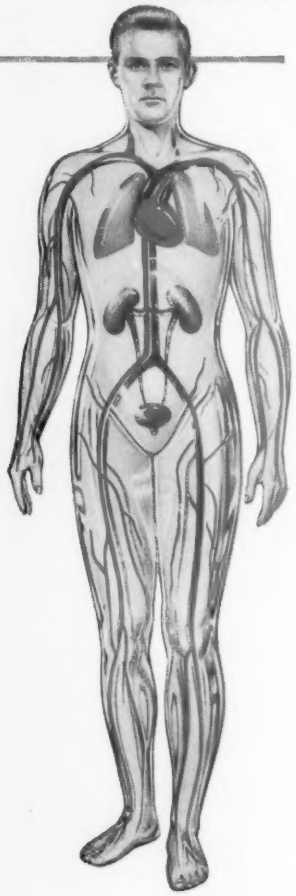
HYDRODIURIL (HYDROCHLOROTHIAZIDE)

- highly-active derivative of chlorothiazide
- qualitatively similar to DIURIL® but at least 10 to 12 times more potent by weight
- loss of potassium is clinically insignificant in the great majority of patients on normal diets

HYDRODIURIL*

NEW RELEASE

HYDROCHLOROTHIAZIDE



IN HYPERTENSION:

- effective by itself in some patients—markedly potentiates other antihypertensive agents
- provides background therapy to improve and simplify the management of all grades of hypertension
- has been reported by some investigators to have a greater antihypertensive effect in some patients than chlorothiazide at equivalent dosage
- does not lower blood pressure in normotensives
- reduces dosage requirements for other antihypertensive agents, often with concomitant reduction in their distressing side effects
- smooths out blood pressure fluctuations

precautions: It is important that the dosage be adjusted as frequently as the needs of the individual patient demand. When HYDRODIURIL is used with a ganglion blocking agent, it is mandatory to reduce the dose of the latter by at least 50 per cent, immediately upon adding HYDRODIURIL to the regimen.

HYDRODIURIL has shown no adverse effects on renal function; for this reason it may be used with excellent results even in patients for whom the organomercurials are contraindicated because of renal damage.

The excretion of potassium is much lower than that of sodium or chloride and, as is the case with DIURIL®, the loss of potassium is clinically insignificant in the great majority of patients on normal diets. If indicated, potassium loss may easily be replaced by including potassium-rich foods in the diet (orange juice, bananas, etc.).

MERCK SHARP & DOHME
Division of Merck & Co., INC. Philadelphia 1, Pa.

Organization cont. from 85

Evening

6:30—Cocktails, Dinner, Entertainment — Wort Hotel, Jackson, Wyoming. Sponsored by Pfizer.

Saturday, June 13

Morning

8:30—Movie, H. W. Seiger, M.D.—Explorers Room. Gold Coning of the Uterine Cervix.
9:00 to 12:00—House of Delegates Meeting—Basement of the Explorers Room.
12:30—Society Sponsored Luncheon — Explorers Room.

Afternoon

Presiding—U. R. Bryner, M.D., President, Utah State Medical Association.
1:30—(Not announced.) Edgar J. Poth, M.D.
2:00—The Value of Curettage in Abnormal Uterine Bleeding, Ralph C. Benson, M.D.
2:30—Syndromes Associated With Hyperplasia or Tumors of the Adrenal Cortex, Edward H. Rynearson, M.D.
3:00—Recess to view exhibits.
3:30—The Treatment of Antepartum Hemorrhage, Ralph C. Benson, M.D.
4:00—Practical Problems in the Management of Thyroid Disease, John Z. Bowers, M.D.
4:30—Surgical Treatment of Ruptured Cervical Intervertebral Disc, Ralph M. Stuck, M.D.
5:00—Meeting of the Council of the Wyoming State Medical Society.
5:30—Cocktails and Barbecue. Place to be anncunced at Registration Desk.

WOMAN'S AUXILIARY

NOTE: Auxiliary Meetings will be held in the West Conference Rooms just off the Explorers Room.

Thursday, June 11

3:00 p.m.—Pre-Convention Board Meeting—State Officers, Standing and Special Committee Chairmen and County Presidents.
6:30 to 7:30 p.m.—Cocktail Party.
7:30 p.m.—No Host Dinner in Dining Room following the Cocktail Party.
Cards and tables will be available for those who wish to play bridge.

Friday, June 12

10:00 a.m.—General Convention Meeting. All wives of members of the Wyoming State Medical

Society are invited to attend.
1:00 p.m.—Luncheon. Guest speaker, George H. Phelps, M.D., Chairman of State Civil Defense for the Medical Society.
3:00 p.m.—Post-Convention Board Meeting to be held by Mrs. O. C. Reed.

Saturday, June 13

Free for sightseeing.

Officers, Wyoming State Medical Society

L. Harmon Wilmoth, M.D., President.
Benjamin Gitlitz, M.D., President-Elect .
Francis A. Barrett, M.D., Vice President.
S. J. Giovale, M.D., Secretary.
C. D. Anton, M.D., Treasurer.
A. T. Sudman, M.D., Delegate to A.M.A.
B. J. Sullivan, M.D., Alternate Delegate to A.M.A.
Arthur R. Abbey, Executive Secretary.

Officers, Woman's Auxiliary to the Wyoming State Medical Society

Mrs. E. W. Gardner, President.
Mrs. O. C. Reed, President-Elect.
Mrs. J. E. Hoadley, First Vice President.
Mrs. Benjamin Gitlitz, Second Vice President.
Mrs. W. Thaler, Recording Secretary.
Mrs. W. H. Pennoyer, Treasurer.

Program Committee

L. Harmon Wilmoth, Chairman; Benjamin Gitlitz, Francis A. Barrett, S. J. Giovale, Edward Gallaghan, Harry B. Tipton, Paul R. Holtz, Bernard D. Stack.

Entertainment Committee

John H. Froyd, Chairman; Robert L. Fernau, Harold F. Edwards, Donald G. MacLeod.

Orientation Committee

Benjamin Gitlitz, Chairman; Glen Koford, Franklin D. Yoder, J. Cedric Jones, William J. Thaler, Mr. Arthur R. Abbey.

Scientific and Commercial Exhibits Committee

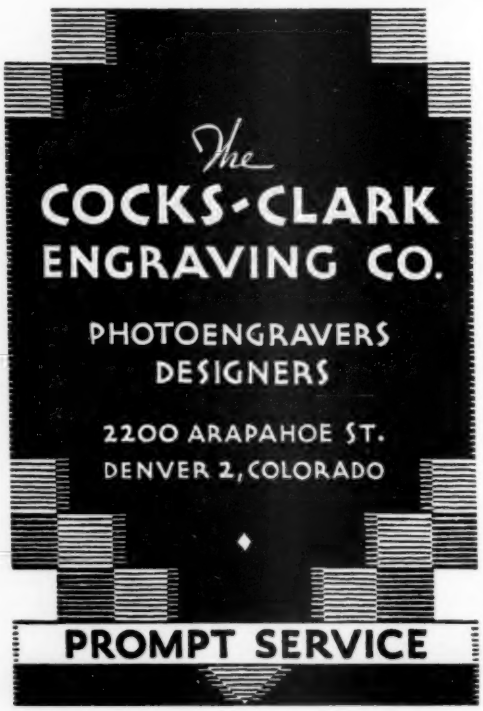
Francis A. Barrett, Mr. Arthur R. Abbey.

Auditing Committee

Francis A. Barrett, G. W. Koford.

Wyoming Conference of Social Work

In view of the Forand type legislature and other matters pertaining to the social needs of our population, physicians will be interested in the annual Wyoming Conference of Social Work to be held at Sheridan, August 23, 24, 25, 1959. The conference is being planned to stress the multi-



disciplinary responsibility for developing and evaluating public and voluntary "services to people." Among the serving professions to be present in addition to physicians will be clergymen, nurses, educators, legalists, social workers and interested laymen. Further information about the program can be obtained from the Conference Program Chairman, Shad J. Hoffman, State Office Building, Cheyenne, Wyoming.

Obituaries

ALBERT R. TAYLOR

Albert Richards Taylor, M.D., 60, Cheyenne, Director of Maternal, Child Health and Crippled Children for the Wyoming Department of Public Health, died of carcinoma (duodenum) November 9, 1958.

Born in Provo, Utah (May 18, 1898), he graduated from the University of Utah. He was granted his M.D. from New York University and Bellevue Hospital Medical College in 1927 and was the fourth generation of his family to graduate from this institution.

Following private practice in Provo and a period of service with the Civilian Conservation Corps, he began his public health career by attending the University of California School of Public Health. Following graduation, he has served as Director of the Division of Maternal, Child Health and Crippled Children in Wyoming. He was a veteran of World War I and World War II. Surviving are his wife and four sons.

WILLIAM B. SUMMERS

William Boyd Summers, M.D., 32, Casper, died suddenly while on a business trip to Denver December 2, 1958. Dr. Summers was born in Lordsburg, New Mexico (February 3, 1926), attended the University of Colorado, receiving his M.D. Degree from their school of medicine in Denver, June, 1951. Prior to his medical training he had been an overseas veteran of World War II, serving in the infantry.

He had practiced in Casper for two and one-half years. He is survived by his wife and two daughters.

JOSEPH F. WHALEN

Joseph Francis Whalen, M.D., 55, Evanston, died March 21, 1959. The Uinta County Coroner reported that Dr. Whalen apparently shot his wife and then himself at their Wyoming State Hospital residence.

Dr. Whalen was born in Mattoon, Illinois, July 3, 1903. He took his pre-medical work at the University of Nebraska and received his M.D. Degree from the University of Nebraska in 1927. He served his internship in Douglas County Hospital in Omaha and took post-graduate work at Boston City Hospital. His Wyoming license was issued in 1929 and he began private practice in

Green River. Dr. Whalen was appointed Superintendent of the Wyoming State Hospital at Evanston in 1936. He had been continuously in that position except for military leave during World War II (1942-1946). Dr. Whalen during his term as superintendent was a devoted worker in treating the mentally ill and maintained a close relationship with private medicine.

Dr. Broxon's suit is dismissed

At the request of attorneys for William D. Broxon, M.D., his suit against the Colorado State Medical Society seeking a permanent injunction against enforcement of the Society's official interpretation of the Principles of Medical Ethics regarding the Free Choice of Physican principle was dismissed in the Denver District Court on March 28. Dr. Broxon is associated with the United Mine Workers of America Welfare and Retirement group in Trinidad, Colorado.

The action had been filed by Dr. Broxon, a member of the Society, in June, 1958. Judge George H. Blickhahn of Alamosa, Colorado, had been selected to preside over the case, and the same judge had previously been appointed by the Colorado Supreme Court to preside over a previous suit—still pending—brought against the Las Animas County Medical Society of Trinidad and most of its members. This latter suit was filed in November, 1957, by Drs. Stanley H. Biber and Robert D. Carlson, both of Trinidad. Drs. Biber and Carlson are not members of the Society, and based their suit largely upon rejection of their applications for membership. They are also associated, but in a different manner, with the U.M.W.A. Fund.

Two years ago the Colorado State Medical Society's Board of Councilors issued an official opinion, effective May 1, 1957, holding in substance that the Society and its component county and district societies should consider it a breach of medical ethics if a physician took part in any closed-panel system of practice whereby patients were, by economic compulsion or otherwise, denied a reasonable free choice of physician. The U.M.W.A. Fund and its physicians appeared to take the position that the opinion was aimed particularly at that Fund's program in southern Colorado.

Dr. Broxon was then, and still was at the time of dismissal of his suit, a participating physician in the U.M.W.A. plan. In Trinidad the plan operates through a group of five physicians who office

together. Drs. Biber and Carlson have stated in court depositions that they are paid a regular monthly lump sum by the U.M.W.A. Fund and also receive 90 per cent of their overhead expenses including all nurses' and secretarial salaries from the U.M.W.A. fund. The other three physicians in the group, one of whom is Dr. Broxon, are presumably on a fee-for-service basis with the U.M.W.A. Fund and presumably receive no overhead expense help.

Dr. Broxon's suit filed last year charged that he was facing probable expulsion from the Colorado State Medical Society because of his association with the U.M.W.A. Fund, and his suit claimed that the official opinion of the Colorado Society's Board of Councilors was "contrary to the interests of public health and welfare of the people of the State of Colorado" and that the Society's opinion that patients should have Free Choice of Physicians as a matter of ethics should be declared "unlawful."

This suit is now officially and finally dismissed. At the same time it was announced by Dr. Broxon's attorneys that he will leave the State of Colorado in June, 1959.

The related and partly similar suit filed six months earlier by Drs. Biber and Carlson is still pending. It is in the District Court for Las Animas County. These two physicians originally asked the court for $75,000 damages each, on the grounds that their practice had been hurt by an alleged "conspiracy" entered into by seven of the then ten members of the County Society. (One of the seven, Dr. Ben B. Beshoar, has died since the suit was filed, and the suit has been dismissed so far as he was concerned.) Drs. Biber and Carlson also asked for a court order prohibiting the local medical society from continuing to deny them membership on the "sole" grounds that they were associated closely with the U.M.W.A. closed-panel system. Finally, the suit asked the court to enter a declaratory judgment holding that Dr. Biber's and Dr. Carlson's system of practice under direct subsidy of the U.M.W.A. Fund would be legal under the Colorado Medical Practice Act. It was pointed out that the local medical society had claimed publicly that the U.M.W.A. doctors were violating the corporate-practice-of-medicine-prohibition, in which the Colorado Medical Practice Act is admittedly one of the strictest in the nation.

In January of this year, Drs. Biber and Carlson, through their attorneys, dismissed the damage-claim part of their suit by amending their original complaint. It was argued in court by the medical society's attorneys that this was done in an unacceptable effort or "strategy" to prevent inquiry into the doctors' financial relationships with the U.M.W.A. Fund. In pre-trial depositions taken in late January, Drs. Biber and Carlson, on advice of their attorneys, had refused to answer any financial questions except to admit that they

are paid a fixed monthly "amount," are reimbursed for 90 per cent of their overhead expense, and are reimbursed for the cost of almost all of their office and hospital equipment and instruments, all by the U.M.W.A. Fund.

Arguments by attorneys for both sides took place before the court in late March as to whether or not the court should force Drs. Biber and Carlson to answer questions concerning their finances. Briefs will be filed by both sides on these questions during April and May and a decision on that aspect of the suit may be forthcoming in late May or early June.

Children's Hospital Summer Clinics June 24-26

The Eleventh Annual Summer Clinics of the Denver Children's Hospital will be held June 24, 25, and 26, 1959. Guest faculty to augment the medical staff and local teachers include J. Roswell Gallagher, M.D., Chief of the Adolescent Unit, Boston Children's Hospital; F. Howell Wright, M.D., Professor and Chairman of the Department of Pediatrics, University of Chicago School of Medicine; and Judge Leo B. Blessing, LL.D., Judge of the Juvenile Court, New Orleans, Louisiana.

In addition to a series of small-group round tables on recent developments applicable to general pediatric care, serious attention will be directed to the social—and medical—problems the teen-ager must adjust to, or overcome, before finding acceptable status in the community. The increasing frequency with which the physician is called upon by perplexed parents, school authorities, law enforcement agencies, and civic groups for authoritative advice makes this year's program most timely. Cost of the course, including luncheons and banquet, remains at $35.00.

Further information may be secured by addressing the Chairman, Summer Clinics Committee, Children's Hospital, Denver 18, Colorado.

Recap of the Rural Health Conference, Wichita, Kansas

This year I was again privileged to attend the Rural Health Conference held in Wichita, which is annually sponsored by the A.M.A. It was considered one of the best conferences ever presented, and the Kansas Medical Society and its Rural Health Committee under the able chairmanship of Dr. V. E. Brown should certainly be congratulated. With the meeting so close, I was sorry to see only a handful from Colorado out of a total registration of 700.

The meeting was opened by Dr. Crockett, who is serving his 14th year as chairman, and his leadership contributed much toward making the conference outstanding. He stressed the need for doctors in small communities, and also the rising cost of hospitalization. Eight suggestions as to

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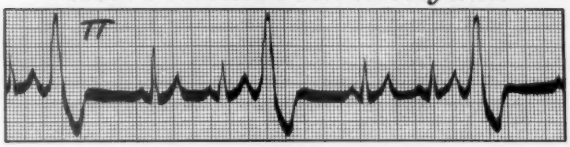
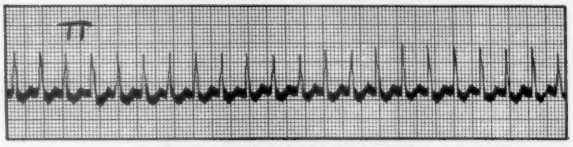
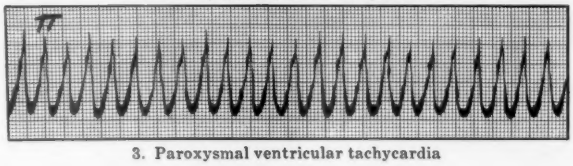
restore normal sinus rhythm



1. Premature ventricular contractions



2. Paroxysmal auricular tachycardia



3. Paroxysmal ventricular tachycardia

in arrhythmias

VISTARIL* hydroxyzine pamoate

More than a tranquilizer

SPECIFIC ANTIARRHYTHMIC EFFECT

Vistaril is effective in ventricular extrasystoles and paroxysmal tachycardias (both auricular and ventricular).

plus

PSYCHOTHERAPEUTIC POTENCY

proven calming action indicated for arrhythmia patients.

and

THE OUTSTANDING SAFETY

of Vistaril as compared to other antiarrhythmic drugs in general use has been noted by investigators.

THE FOLLOWING DOSAGE REGIMEN IS RECOMMENDED

(individualized by the physician for maximum effectiveness):

PARENTERAL DOSAGE: 50-100 mg. (2-4 cc.) I.M. stat., and q. 4-6 h., p.r.n.; maintain with 25 mg. b.i.d. or t.i.d. In acute emergency, 50-75 mg. (2-3 cc.) I.V. stat.; maintain with 25-50 mg. (1-2 cc.) I.V. q. 4-6 h., p.r.n.

ORAL DOSAGE: Initially, 100 mg. daily in divided doses until arrhythmia disappears. For maintenance or prophylaxis, 50-75 mg. daily in divided doses.

SUPPLY: Vistaril Capsules, 25 mg., 50 mg. and 100 mg. Vistaril Parenteral Solution, 10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. (as the hydrochloride).

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES
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Brooklyn 6, N. Y.

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References: 1. Burrell, Z. I., et al.: Am. J. Cardiol., 1:624 (May) 1958. 2. Hutcheon, D. E., et al.: J. Pharmacol. & Exper. Therap., 118:451 (Dec.) 1956.

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...a new way to relieve pain and stiffness in muscles and joints

INDICATED IN:

MUSCLE STIFFNESS

LUMBOSACRAL STRAIN

SACROILIAC STRAIN

WHIPLASH INJURY

BURSITIS

SPRAINS

TENOSYNOVITIS

FIBROSITIS

FIBROMYOSITIS

LOW BACK PAIN

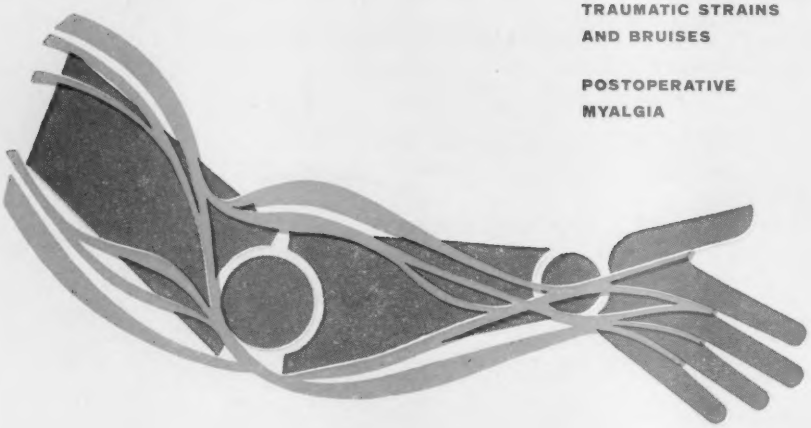
DISC SYNDROME

SPRAINED BACK

"TIGHT NECK"

TRAUMATIC STRAINS AND BRUISES

POSTOPERATIVE MYALGIA



■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA™

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

■ More specific than salicylates ■ Less drastic than steroids

■ More effective than muscle relaxants

SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with any previously used analgesic, sedative or relaxant drug.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white sugar-coated 350 mg. tablets.

Literature and samples on request.

WALLACE LABORATORIES, NEW BRUNSWICK, N. J.

Organization cont. from 94

what communities can do if they do not have a doctor were outlined by Dr. Crockett and later covered in more detail.

Dr. Louis M. Orr, President-Elect of the A.M.A., spoke very highly of the Kansas plan which has helped put at least one doctor in every Kansas community over 1,000. This plan has helped increase the enrollment in the Kansas Medical School, and provides a means of financial assistance to capable students. He stressed the fact that doctors should be more active in community affairs, and also the family doctor's ability to give complete medical care to at least 85 per cent of his patients.

Dr. E. L. Butz, Dean of the College of Agriculture of Purdue University, discussed the "do it yourself" age in which we are living and that we should take pride in doing things for our community. The problem today is to do it yourself or let the federal government do it for you. According to a well known law of physics, government will move into a void and for every dollar sent to Washington only 60 cents is returned, plus numerous bureaucratic blanks to be completed. This trend can be reversed only by action and not by words. Dr. Butz also stressed the fact that a city limit sign is only a tax boundary, and the people on either side are in need of the same type of medical care. He mentioned that the more involved we are with government control the more difficult it is to get out from underneath such controls. Confucius is supposed to have said, "He who rides the tiger should have plans for dismounting." We must avoid having the government as our senior partner in our health program.

Thursday afternoon was devoted to a workshop in community health participation, where various phases of health problems in Kansas communities were discussed. This type of workshop given by a team of qualified workers is available to any Kansas community desiring its services. It was stated that public apathy was the greatest problem in every community.

The next morning started with reports from the Kansas Farm Bureau, the National Grange and finally from Mr. Aubrey Gates, who has been associated for numerous years with these meetings and is now the head of the Division of Field Services of the A.M.A. He told the ancient fable of the Little Red Hen which again brought out the attitude of so many people these days: Why work to save anything for a rainy day? As M.D.s we should try to help people to help themselves instead of relying on government help. Mr. Gates spoke of the rejection of the aged and their care in some so-called nursing homes. His speech was followed by reports on the family physician and the cost of medical care and health insurance. Mr. John Pond, management consultant of Lari-

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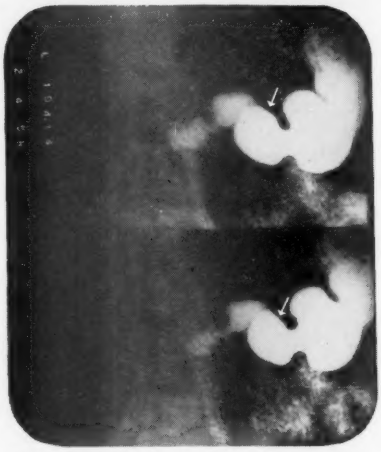
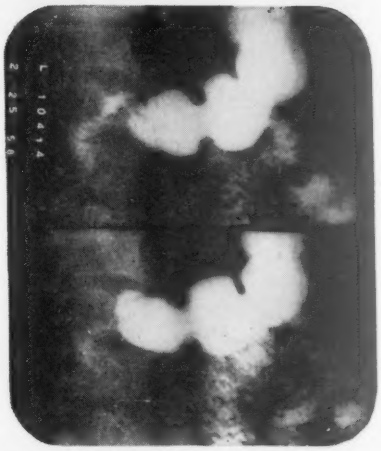
—and control its G.I. sequelae



Patient A.S., age 53.
Intermittent crises of severe pain over 2 year period; hospital management with Sippy regimen provided relief of symptoms; however, symptoms recurred after each sojourn.



PATHIBAMATE *(Tabs. j t.i.d. and H.S.);* prompt relief of symptoms. Radiograph (21 days later) confirms healing of minute lesser curvature gastric ulcer crater.

predictable results in the control of tension and G.I. trauma

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Meprobamate with PATHILON® Tridihexethyl Chloride* LEDERLE

Used prophylactically in anticipation of periods of emotional stress, or therapeutically to relieve tension and curb hypermotility and hypersecretion, PATHIBAMATE is particularly well-formulated for the control of gastrointestinal disorders.

PATHIBAMATE combines Meprobamate (400 mg.) — the noted tranquilizer-muscle relaxant widely accepted for safe management of tension and anxiety states — and PATHILON (25 mg.) — an extremely well-tolerated anticholinergic, long noted for prompt symptomatic relief based on peripheral atropine-like action with few side effects.

Indications:
Duodenal ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety neurosis with gastrointestinal symptoms, gastric hypermotility.

Supplied:
Bottles of 100 and 1,000. Each tablet (yellow, ½-scored) contains Meprobamate, 400 mg.; PATHILON Tridihexethyl Chloride, 25 mg.

Administration and Dosage:
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Also Available: PATHILON in four forms — *Tablets* of 25 mg., plain (pink) or with *phenobarbital*, 15 mg. (blue);
Parenteral — 10 mg./cc. — 1 cc. ampuls;
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*PATHILON is now offered as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could interfere with the results of certain thyroid function tests.

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Organization cont. from 98

mer County Hospital in Fort Collins, explained why hospital care is so high today and how the hospital dollar is spent.

Mental health was the topic for the afternoon. Dr. Alonzo Peeke, a general practitioner of South Dakota, was the first speaker. He stressed the fact that since he knows the emotional involvement and family background of so many of his patients, he can easily determine that Mrs. Smith's headaches started because John is drinking again. He gave us information on the South Dakota Mental Health Association, and all the help this group has been to organized medicine and the Yankton State Hospital. Then we heard Dr. Prescott W. Thompson of the Meninger Clinic stress that good practices of psychiatry required cheerful surroundings and the feeling of hope in the treatment of mental illness.

The highlight of the annual banquet was a talk given by Dr. T. P. Butcher, President of K.M.S., a farmer, social scientist, and a well known Kansas surgeon. With vivid demonstrations he brought out the various aspects of the four dimensions in the world in which we live. His fifth dimension, the element of faith, is the human factor present in every calculation man makes. It is his awareness of himself in relation to all else in time and space.

Mrs. E. A. Underwood, President of the Woman's Auxiliary of the A.M.A. and a practicing dentist in the State of Washington, spoke on dental health. She very seriously advocated the use of fluorine in all deficient water supplies, a serious rural health problem.

Mrs. Kenneth Schneider, wife of a young rural practitioner of Nashville, Indiana, told of all the advantages of a rural practice from the doctor's wife's standpoint, which should surely encourage and convince a number of students to enter the field of general practice.

Mr. Paul C. Johnson, Editor of the Prairie Farmer, then summarized and evaluated the meeting, giving helpful ideas for the solution to many of the problems discussed.

I was very much impressed by our last speaker, Chancellor Franklin P. Murphy of Kansas University, a well known M.D., whose speech was based on rural health, past, present and future. He suggested more planning in the medical organization of any given area. A two-year hospital training plan for rural practitioners was almost mandatory, a suggestion which is one of the main aims of the American Academy of General Practice. He stressed as outmoded the solo practice of medicine and brought out all the points in favor of group practice even in rural areas. Chancellor Murphy concluded his talk with a report on his recent visit to Russia. Three times as much is spent on higher education in Russia and the people there have the intense conviction that their country will be the most powerful in the near future. Educators and the professional people in the U.S.S.R. have a much greater prestige than they have in our country, Dr. Murphy brought out. He left us with the thought that the need for greater interest in education and health is urgent.

Along with the valuable and effective program offered and the opportunity to exchange views and ideas with those of other areas, we left the conference with a satisfied feeling of time well invested.

V. E. Wohlauer, M.D., Chairman,
Rural Health Committee,
Colorado State Medical Society.

Obituaries

Former Mental Health Director dies

Wray R. Gardner, M.D., of Denver, 54, died suddenly on January 28, 1959, of a heart attack. Dr. Gardner was born in Colorado Springs on May 16, 1904. He was graduated from Colorado College in 1926 and received his medical degree from the Colorado University Medical School in 1930. He interned at Colorado General Hospital and was a resident psychiatrist at Colorado Psychopathic Hospital from 1946-49. Dr. Gardner served with the army from 1933 to 1946, retiring with the rank of colonel. He was Mental Health Director of the Colorado Public Health Department in 1949. He was a member of the Colorado

Neuropsychiatric Society and a fellow of the American Psychiatric Association. He is survived by his wife and two sons.

Durango physician dies

James Walker Clark, M.D., of Durango died on February 4, 1959. Dr. Clark was born in Plainview, Texas, on May 25, 1915, and studied at the Texas Technological College at Lubbock, Texas. He interned at the Robert B. Green Memorial Hospital and was licensed in Texas as well as in Colorado. He became a member of the San Juan County Medical Society in 1947.

A Life Emeritus member dies

Daniel Fred Richards, M.D., Denver, 78, died March 9, 1959. Dr. Richards was born in De Soto, Missouri, in 1881 and studied medicine in Colorado. He was elected to membership in the State Medical Society in 1916. During the last two years, he held a Life Emeritus Membership.

W. E. Harris, M.D., new Secretary-Treasurer

At the Twelfth Interim Session of the Montana Medical Association held in Helena, April 3-4, its House of Delegates elected W. E. Harris, M.D., Livingston, Montana, to the office of Secretary-Treasurer to succeed the late T. R. Vye, M.D. Dr. Harris has served as Assistant Secretary-Treasurer of this Association from September, 1957, until the death of Dr. Vye, when he became Acting Secretary-Treasurer.

Jess T. Schwidde, M.D., 1231 North 29th Street, Billings, Montana, was elected Assistant Secretary-Treasurer to succeed Dr. Harris. Dr. Schwidde, as well as Dr. Harris, will hold office until the next regular election which will be held during the Annual Meeting of this Association in September, 1959.

Obituaries

W. L. DuBOIS

Walter Lynn DuBois, M.D., Conrad, died at his home in Conrad, March 14, 1959. Dr. DuBois was born on September 4, 1880, at Wichita, Kansas. He received his B.S. Degree from the University of Iowa in 1902 and his M.D. Degree from Northwestern University Medical School in 1906. He moved to Conrad, Montana, for the general practice of medicine in 1910 and remained in that community until his retirement in 1951.

Dr. DuBois was very active in community affairs and served several terms as a member of the Conrad School Board. Dr. DuBois had been an active member of the Northcentral Montana Medical Society, this Association and the A.M.A.

A. A. DODGE

Albert Arthur Dodge, M.D., died at his home in Kalispell after a brief illness, March 3, 1959. Dr. Dodge was the oldest practicing physician in Montana. He was born January 28, 1868, in Farmington, Minnesota. He received a B.S. Degree from the University of Minnesota in 1891 and an M.D. Degree from the University of Minnesota Medical School in 1894. Dr. Dodge was engaged in the practice of medicine and surgery in Faribault, Minnesota, for several years. After undertaking postgraduate training in Chicago in 1914, he moved to Kalispell where he was engaged in the general practice of medicine until a few days prior to his death.

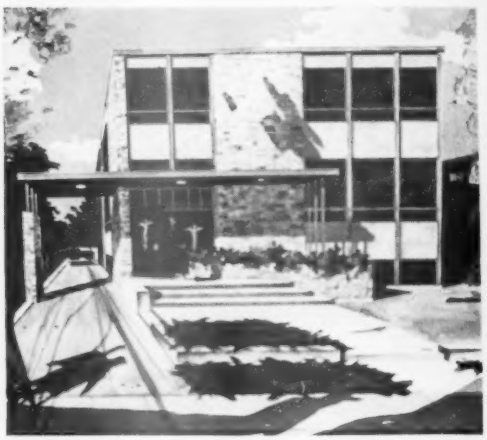
Dr. Dodge was an active member of this Association and until a few years ago attended nearly all of its annual and interim sessions. He engaged in many community activities and was an enthusiastic supporter of the Flathead Valley. He was a member in good standing of the Flathead County Medical Society, this Association and the American Medical Association during his entire medical career in Montana.

C. F. LITTLE

Charles Francis Little, M.D., Great Falls, died suddenly in Denver on March 19, 1959, while visiting relatives on his return to Great Falls following a vacation. Dr. Little was born in Washington County, Kansas, February 17, 1892. He received his M.D. Degree from the Creighton University School of Medicine in 1921. Following graduation he practiced medicine in Omaha and Denison, Iowa. In 1933, Dr. Little was awarded a Master of Science Degree in internal medicine from the University of Pennsylvania School of Medicine. In 1935 he moved to Great Falls where he engaged in the practice of internal medicine until his retirement in May, 1958.

continued on next page

Dr. Little was a very active member of this Association and participated in the activities of many of its committees. He was an active member of the Cascade County Medical Society, this Association and the American Medical Association as well as a Fellow of the American College of Physicians.



State Association dedicates building

The Utah State Medical Association formally dedicated its remodeled headquarters on March 25, 1959. The building is now open for inspection, and you are urged to visit your new headquarters when in Salt Lake City.

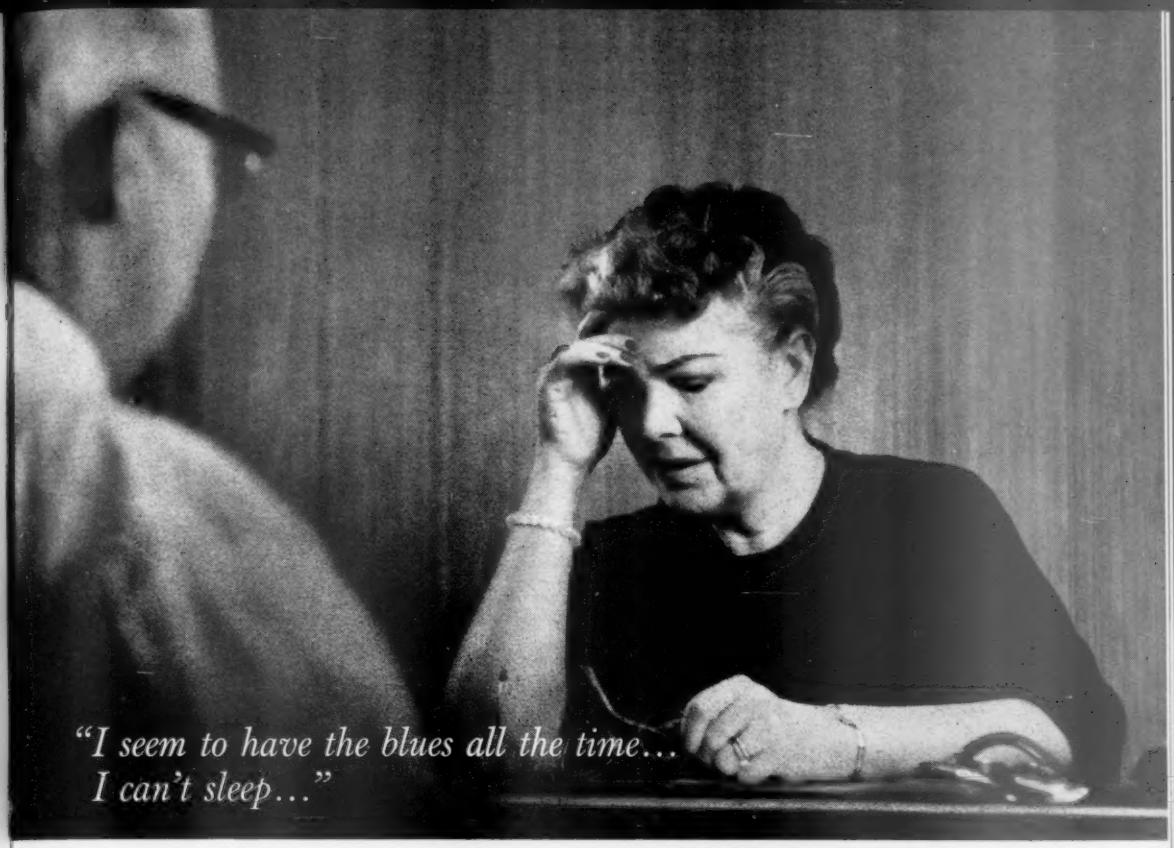
Obituary

JOHN R. LLEWELLYN

John Rees Llewellyn, M.D., 72, well-known general practitioner, died February 6, 1959, in a Salt Lake rest home. Death was due to a stroke.

Dr. Llewellyn graduated from Brigham Young University, Provo, in 1906, after which he taught high school in Price for two years. He then continued his studies at the University of Utah for another two years before enrolling in Rush Medical College in Chicago. He obtained his medical degree from that institution in 1914 and began practicing in Magna and Garfield. In 1920 he came to Salt Lake City and joined the Salt Lake Clinic. He retired from practice in 1953.

He was a former member of the Board of Latter-day Saints Hospital, Salt Lake City Board of Health, Utah State Hospital Board, Utah State Medical Association, Salt Lake County Medical



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References:
1. Alexander, L.: J.A.M.A. 166:1019, March 1, 1958.
2. Current personal communications; in the files of Wallace Laboratories.
3. Pennington, V.M.: Am. J. Psychiat. 115:250, Sept. 1958.

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Society, and served on the draft appeal board during World War II.

He is survived by his mother, widow, four sons, two daughters, two sisters, nine grandchildren and a great grandchild.

NATIONAL AFFAIRS

A.M.A. Meeting to feature Special Session on Aging

A special session on new concepts in aging will be held during the annual convention of the American Medical Association in Atlantic City, June 8-12.

This one-day session, to which all physicians are invited, will be held in Room C of the convention hall at 9 a.m., Wednesday, June 10, under auspices of the A.M.A. Committee on Aging.

The meeting is designed to present the practicing physician with a concentrated review of current thinking regarding health care of the aged, and to provide him with concrete health recommendations which he can translate to his own older patients.

Keynoting the session will be a series of panels devoted to Diseases Among the Aged, Nutritional Counseling, Promoting Physical Fitness, and Motivating the Older Person. Panel members will include Drs. David B. Allman, Leland S. McKittrick, Edward C. Reifenstein, Irving S. Wright, Walter E. Vest, Jr., Frederick C. Swartz, Frederick J. Stare, Clive M. McCay, Margaret A. Ohlson, Henry A. Holle, Norman Lee Barr, Theodore G. Klumpp, Janet Wessell, Edward H. Williams, Ewald W. Bussee, Howard P. Rome, and Cecil Wittson.

These nationally recognized authorities in their fields will cover such points as 1) special treatment aspects of cardiovascular, neoplastic and bone diseases among the aged, 2) effects of adequate nutrition in rehabilitation potential for older patients, 3) variables in prescribing a physical activity program for the older individual, and 4) the effects of physical health, social adjustment and psychological functioning on motivation in the older person.

Each panel presentation will be followed by a discussion period in which the primary interests of the audience will be explored and important ideas summarized. Dr. Edward L. Bortz of Philadelphia will close the session by summarizing the health recommendations brought out during the day in a formula for full living by the aging person.

Physicians planning to attend the session are invited to send questions or points they would

like to see discussed to the Committee on Aging, A.M.A., 535 North Dearborn, Chicago 10, Illinois. The areas of interest so indicated will be brought out as far as possible during the session. Queries should be received at A.M.A. headquarters not later than Wednesday, May 27.

National Hospital Week, May 10-16

The nation's hospitals, through the American Hospital Association, have invited their closest ally, the medical profession, to help them develop greater understanding and appreciation of their services and contributions to the American people.

This year's program will emphasize the theme of "More Roads to Recovery." An explanation of these "roads"—better care, improved technics and skills, greater numbers of personnel to apply the dramatic successes of medical science—will help offset a growing myth that hospital costs are greater than the services received.

Such distorted stories not only jeopardize public regard for the hospital but for the entire medical team, including the practicing physician. Consequently, it is to our mutual advantage to work together toward overcoming these detrimental impressions which are gaining some acceptance.

"More Roads to Recovery" are the patient's reward for the close harmony and utilizations of the tools and skills of both the hospital personnel and the medical profession. These rewards can be made more meaningful by your participation in National Hospital Week.

Each physician in the community has a role and responsibility to win public support for the hospital in which he practices. Help your hospital administrator and your hospital association during National Hospital Week, May 10-16, to create a greater appreciation of the entire medical team's efforts.

Third International Congress of Physical Medicine

The Third International Congress of Physical Medicine will be held in Washington, D. C., from August 21 through August 26, 1960. This Congress will assemble physicians and other professional personnel from all parts of the world concerned with the furtherance and scientific development of physical medicine and rehabilitation. This is the first International Congress of such character and magnitude to meet in the United States. International Congresses have been held in London in 1952, and in Copenhagen in 1956.

Convening this international session in the United States will provide to a large number of American physicians and other professional personnel an opportunity to exchange with foreign visitors scientific information concerning physical medicine and rehabilitation. Such exchange of scientific information is necessary and helpful for the continued improvement and expansion of physical medicine and rehabilitation services to the American public. Equally great will be the educational benefits to physicians and other professional personnel attending the Congress.

It is objective of the Congress to further the development of knowledge and professional and technical skills through the exchange of information concerning the advances made in the field of physical medicine and rehabilitation.

Papers will be presented by experts in all fields of medicine and surgery together with other aspects of rehabilitation—social, educational and vocational. Delegates are expected from 30 countries. These delegates and participants will represent their respective scientific organizations. Those in attendance from the United States will represent private and governmental facilities, agencies, and services and local, state and national medical societies.

The exchange of information will be expedited through plenary sessions, special and sectional meetings, formal papers and discussion groups. An exhibition will be held in connection with this assembly which will include exhibits from many countries. The exhibits will be both scientific and technical in nature and it is expected that they will demonstrate graphically developments in all phases of physical medicine and rehabilitation. To stimulate interest an award will be given for the best exhibit. Walter J. Zeiter, M.D., Secretary, 30 N. Michigan Ave., Chicago. continued on next page

WOMAN'S AUXILIARY

1959 Convention

More than 2,500 physicians' wives will gather at Atlantic City's Hotel Haddon Hall June 8-12 for the 36th annual convention of the Woman's Auxiliary to the American Medical Association.

National committee meetings and round table discussions will be held June 6-8 with formal opening of the convention slated for Tuesday morning, June 9.

Business sessions on Tuesday and Wednesday—presided over by Auxiliary President Mrs. E. Arthur Underwood of Vancouver, Wash.—will be devoted to state and national committee reports and discussions on current projects, including civil defense, mental health, allied medical careers, automobile safety and community service.

Tuesday's luncheon in honor of Auxiliary national Past Presidents will feature guest speaker Aubrey Gates, director of A.M.A.'s Field Service Division, on "Talking to Congressmen Back Home."

During Wednesday's general meetings, Frank R. Burrows, Jr., field service director of Chicago's Citizens Traffic Safety Board, will discuss the driver's responsibilty in auto safety in his speech entitled, "You Can Get Blood Out of a Turnip."

A report on alcoholism will be given by Dr. Marvin A. Block, Chairman of the A.M.A.'s Committee on Alcoholism, as part of the Auxiliary's Mental Health Committee program.

Election and installation of national officers will be held Thursday morning with adjournment scheduled for noon. At this time Mrs. Frank Gastineau will give her inaugural address as new President of the Woman's Auxiliary.

A postconvention workshop for national officers, directors, committee chairmen, state Presidents and Presidents-Elect will be held Friday morning to discuss upcoming programs and projects. Dr. Ernest B. Howard, A.M.A. Assistant Executive Vice President, will speak on new A.M.A. activities.

All Auxiliary members, their guests and guests of physicians attending the A.M.A.'s Annual Meeting in Atlantic City at the same time may participate in all social functions and attend the general meetings of the Auxiliary.

Local convention arrangements are under the direction of Mrs. David B. Allman of Atlantic City, General Chairman. One of the outstanding social events of the convention will be the annual tea in honor of the Auxiliary President and President-Elect on Monday afternoon, sponsored by Pfizer and Company, a drug firm.

Oregon Cancer Conference

An Oregon Cancer Conference is being held July 16 and 17, 1959, in Portland under the joint sponsorship of the Oregon State Medical Society, the Oregon Division of the American Cancer Society, the University of Oregon Medical School and the Oregon Academy of General Practice. The Conference is planned for midsummer as a special feature of the Oregon Centennial celebration.

The guest speakers for the two-day Cancer Conference will include Dr. Arthur C. Allen, Professor of Pathology, and Dr. Ralph Jones, Jr., Professor of Medicine, both from the faculty of the University of Miami School of Medicine at Coral Gables, Florida; Dr. Gilbert H. Fletcher of Houston, Texas, Radiologist, Tumor Institute of the M. D. Anderson Hospital; Dr. Leslie M. Smith, Dermatologist of El Paso, Texas; Dr. Bayard Carter, Professor of Obstetrics and Gynecology, Duke University School of Medicine; Dr. Gilbert Dalldorf, Albany, New York, Director, Medical and Scientific Research Department of the National Foundation, and Dr. Englebert Dunphy of Portland, Professor of Surgery, University of Oregon Medical School. In addition to their individual presentations, each guest speaker will participate in one or more panel discussions.

The program is being developed under the direction of the Committee on Cancer of the Oregon State Medical Society. Dr. Martin A. Howard of Portland is Chairman. All sessions of the conference will be held in the Library Auditorium at the University of Oregon Medical School except the banquet on the evening of July 16 which will be held at the Hotel Multnomah in Portland. The entire expense of the conference is being underwritten by the Oregon Division of the American Cancer Society. There will be a charge, however, for the banquet.

A block of rooms has been reserved at the Hotel Multnomah for physicians wishing to attend the conference. A copy of the complete program and hotel reservation forms may be obtained by writing to Roscoe K. Miller, Executive Secretary, Oregon State Medical Society, 1115 S. W. Taylor Street, Portland 5, Oregon.

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THE BOOK CORNER

New books received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.

Current Therapy—1959: Edited by Howard F. Conn, M.D. Philadelphia, W. B. Saunders Company, 1959. 781 p. Price: $12.00.

The Anatomy of the Nervous System: By Stephen Walter Ransom, M.D., Ph.D., revised by Sam Lillard Clark, Ph.D. 10th edition. Philadelphia, W. B. Saunders Company, 1959. 622 p. Price: $9.50.

Diseases of the Colon and Anorectum: Edited by Robert Turrell, M.D. Two volumes. Philadelphia, W. B. Saunders Company, 1959. Price: $35.00.

New and Nonofficial Drugs—1959: By the Council on Drugs of the American Medical Association. Philadelphia, J. B. Lippincott Company, 1959. 687 p. Price: $3.35.

Maternity; A Guide to Prospective Motherhood: By Frederick W. Goodrich, Jr., M.D. Englewood Cliffs, N. J., Prentice-Hall, Inc., 1959. 130 p. Price: $1.75.

The Plasma Proteins; Clinical Significance: By Paul G. Weil, B.A., M.D.C.M., M.Sc., Ph.D. (London). Philadelphia, J. B. Lippincott Co., 1959. 133 p. Price: $3.50.

Diseases of Metabolism; Detailed Methods of Diagnosis and Treatment: Edited by Garfield D. Duncan, M.D. 4th edition. Philadelphia, W. B. Saunders Company, 1959. 1,104 p. Price: $18.50.

General Urology: By Donald R. Smith, M.D. 2nd edition. Los Altos, Lange Medical Publications, 1959. 328 p. Price: $4.50.

Surgery of the Prostate: By Henry M. Weyrauch. Philadelphia, W. B. Saunders Company, 1959. 535 p. Price: $15.00.

Surgical Pathology: By Lauren V. Ackerman, M.D. 2nd edition. St. Louis, C. V. Mosby Company, 1959. 1,096 p. Price: $15.00.

Now or Never; The Promise of the Middle Years: By Smiley Blanton, M.D. Englewood Cliff, N. J., Prentice-Hall, 1959. 273 p. Price: $4.95.

Childbearing Before and After 35: By Adrien Bleyer, M.D. N. Y., Vantage Press, 1959. 119 p. Price: $2.95.

A Doctor Discusses Menopause: By G. Lombard Kelly, M.D. Chicago, Budlong Press, 1959. 90 p. Price: $1.50.

Textbook of Surgery: Edited by H. Fred Moseley, M.D. 3d edition. St. Louis, C. V. Mosby Company, 1959. 1,336 p. Price: $17.00.

Book Reviews

The Eye in Evolution: By Sir Stewart Duke-Elder. St. Louis, C. V. Mosby Company, 1958. 843 pages. Price: $27.50.

The Eye in Evolution is the first volume of a projected 15-volume *System of Ophthalmology* to be edited by Sir Stewart Duke-Elder. This volume has been written entirely by Sir Stewart. The remainder of the rewriting of the original *Textbook of Ophthalmology* is to be shared with the author's colleagues at the Institute of Ophthalmology in London.

To comment on the author's qualifications is extraneous. He is the world's outstanding living ophthalmologist. To comment on the author's approach to his subject is also extraneous. The text is typical of Duke-Elder: well organized, exhaustive, lucid, readable and entirely fascinating.

The textbook is composed of 22 chapters. Part I deals with the effect of light on living organisms. Herein is contained the effect of light on metabolism, movement, pigmentation and finally the emergence of vision. Part II is concerned with the evolution of the visual apparatus. Considered are the eyes of the most primitive of the invertebrates up the phylogenetic scale through cyclostomes, fishes, amphibians and reptiles to birds and mammals. The section is completed with a consideration of the central organization of vision along the evolutionary scale. Part III is a study of the function of the eyes of animals. Again the invertebrates and vertebrates are considered from the simplest to the most highly developed. Vision of the animal kingdom from the perception of light to the perception of color and the most acute form vision of birds and mammals is examined in detail. Part IV deals briefly with evolutionary by-ways such as median eyes, rudimentary eyes, luminous organs and electric organs.

The book is well printed and profusely illustrated. There is little that is applicable to clinical ophthalmology, but the practitioner will read with delight and absorption about the navigational sense in birds and insects, the spatial judgments of fish and reptiles and a myriad of other fascinating and

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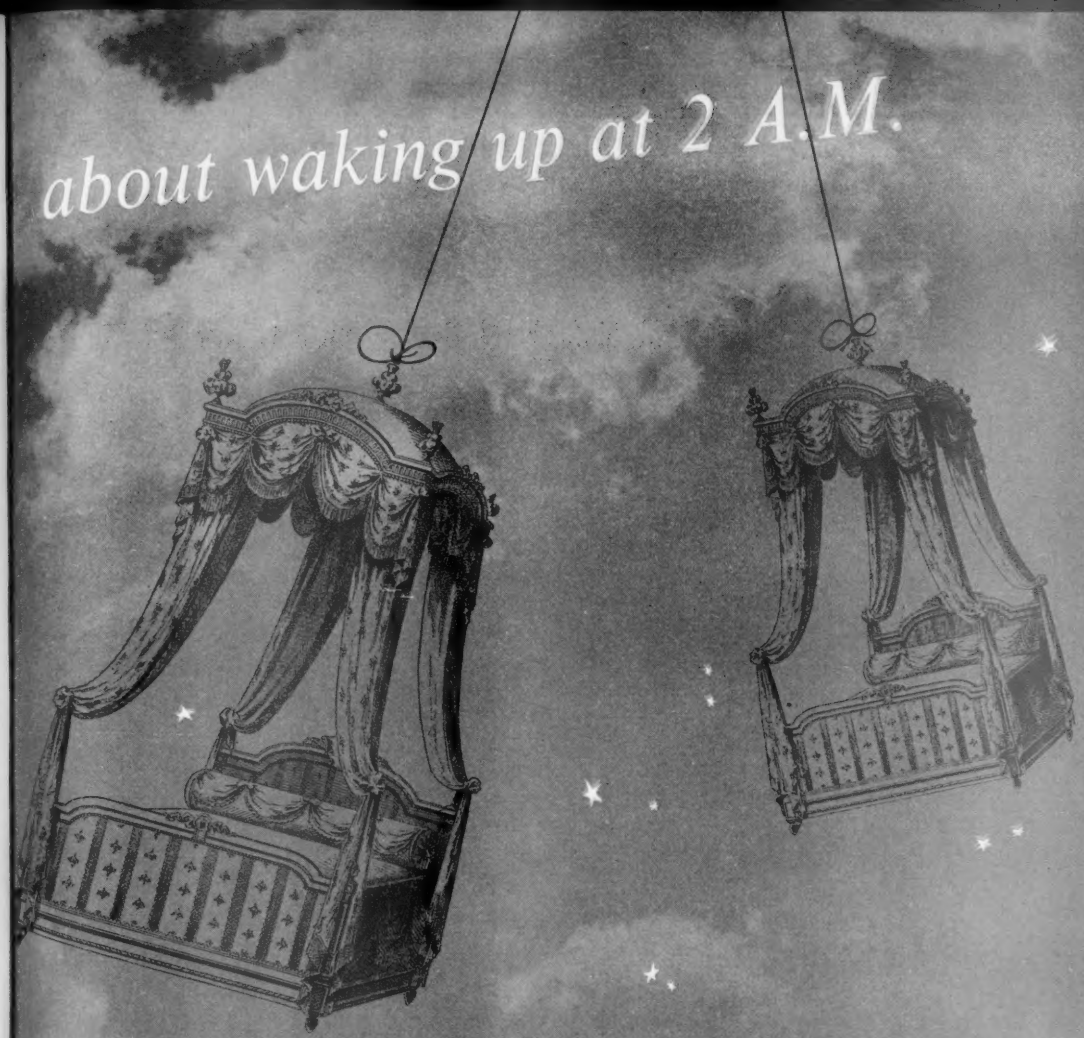

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1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E.: Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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informative facets of the visual world in which we live.

The Eye in Evolution will be welcomed with plaudits by the world of ophthalmology.

Robert L. Weiner, M.D.

Aids to Ophthalmology: By P. McG. Moffat, M.D., London. Eleventh edition. London, Bailliere, Tindall and Cox, 1957. 282 p. Price: $3.00. (Williams and Wilkins Co., Baltimore, exclusive U. S. agents.)

Aids to Ophthalmology is a condensed handbook of value primarily to the medical student and general practitioner. An amazing amount of information is compressed into a very small space. The attempt to touch briefly all phases of ophthalmology necessarily sacrifices some accuracy.

Some of the therapeutic measures advocated by the British author will tend to make his American ophthalmic cousins blush. Thus the application of leeches or blistering the temple for the pain of iritis is not often considered in the United States. The use of reading glasses or bifocals in myopic children is avoided by American ophthalmologists. "Residence at the seaside" is not generally considered "singularly effective" in treatment of tuberculosis iritis. The fact that fluid type scleral contact lenses are the only contact lenses mentioned indicates that in this field, too, the text is outdated.

Although there is considerable worthwhile information in this text it is not recommended. The student for whom it was written does not have the background necessary to extract the wheat from the chaff.

Robert L. Weiner, M.D.

Orr's Operations of General Surgery: By George A. Higgins, M.D., and Thomas G. Orr, Jr., M.D. 3rd edition. Philadelphia, W. B. Saunders Company, 1958. 1016 p. Price: $20.00.

This book is a complete revision of the late Dr. Orr's previous work. It was accepted as a challenge by his associates after his sudden death while the book was in preparation. The text clearly describes many of the technics used in general surgery in a manner which is completely understandable to any surgeon who has had training in general surgery. The book is surprisingly broad in its scope and because of this has to be succinct in most of the sections. In fact there are some obvious omissions which probably will be rectified in subsequent editions. For example, in the section dealing with skin grafts no mention is made of the electric dermatome which is probably more widely used for procuring split-thickness skin grafts than any other apparatus. Similarly in the section dealing with the treatment of varicose veins, the lesser saphenous system is not mentioned.

Of outstanding importance is the excellence of the illustrations. Their position in relation to the text demonstrates the publisher's insight in the

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This book will be particularly helpful to the general surgeon of long experience who wishes to refresh himself with new technics as well as to the recently graduated surgical resident who may want to compare the technics he has just learned with those of the experienced masters.

Bernard T. Daniels, M.D.

Drugs of Choice 1958-1959: Walter Modell, editor. St. Louis, C. V. Mosby, 1958. 931 p. Price: $12.75.

Drugs of Choice is a compendium of essays dealing with the selection of drugs for various therapeutic problems. The chapters are generally well-written by men conversant with the particular problem. As in all works of this nature some chapters are far better than others and some authors tend to overemphasize their favorite drugs and ideas.

The essays are meant only as a guide to the drugs available and thus the choice. To paraphrase one author: "The indications and pharmacological considerations of the drugs discussed are indeed important bits of information. However, the physiologic aspect to the patient that these . . . agents produce when well administered is minute in comparison with the physiologic upheavals that develop when the same agents are given by those who do not understand the changes" in various functions that result.

The essays attempt to explain the effects of the drugs and the changes produced. This is truly a book to stimulate thinking. There are no pat answers, with a specific drug for each condition, but instead, the advantages and disadvantages of the more common ones are discussed. The final decision is left to the individual practitioner.

Donald W. Stein, M.D.

Ciba Foundation Colloquia on Endocrinology, volume II: Hormones in Blood. Boston, Little, Brown, 1958. 416 p. Price: $9.00.

This is a collection of papers and discussions related to measurement of hormones in the blood, given at an international conference, in February, 1957. Keynote of the meeting, sponsored by The Ciba Foundation, was "Back to Blood," emphasizing the need for improved methods in chemical analyses or bioassay of circulating hormones. Thirty-five international authorities and investigators participated.

Clinicians are aware of the relatively crude, often inaccurate, and usually indirect methods of hormone assays presently available. Protein bound iodine levels, directly reflecting the amount of circulating thyroxin, is the happy exception. Recent advancements are documented and difficulties still to be overcome are discussed.

Those interested in hormones will find here a wealth of information and challenging ideas.

J. Philip Clarke, M.D.

Water and Electrolyte Metabolism in Relation to Age and Sex. Ciba Foundation Colloquia on Aging. Vol. 4. Boston, Little, Brown & Company, 1958. 327 p. Price: $8.50.

Very few medical workers in these times are unacquainted with the various series of publications by the Ciba Foundation. The Colloquia on Aging are of the expected high calibre. The previous volume includes studies on the pathological and mental aspects of aging. The present contribution concerns a subject of exceptionally wide interest, and with much credit to the authors and editors it proceeds in a pleasingly readable manner.

This is a presentation of fine points in physiology rather than of any broad principles, and thus it is difficult to give an appreciation of the scope of the conference. Eighteen papers were presented, many of which elucidated the changes and development of renal function in the newborn and the regulation of body water. A particularly graphic study was presented by Kerpel-Fronius of Hungary who showed that while proportion of total body water in infants was comparable to that in adults on basis of body weight, metabolic indicators such as cardiac output and oxygen consumption were extremely high; any loss of the limited reserves in infants would be rapidly felt by the disproportionate and already "strained" circulation. Hormonal relationships to water and salt changes are, of course, variable with the functional state of the glands in regard to age. The decline in renal function in the years beyond 20

was clearly pictured for otherwise young-feeling adults. N. W. Shock of Baltimore has shown by combinations of clearances that apparently individual nephrons drop out as a whole, and that there is in addition a decrease in tubular blood flow as might be expected with aging arterioles; these blood vessels surprisingly, however, are not irreversibly narrowed but dilate to normal size in response to pyrogens. Following each paper the 27 authorities present participated in what might be called "brainstorming" sessions designed to relate usually unallied fields of study. These discussions are worth the price of admission: some of the best ideas may arise in the interchange between researcher and clinician, further elucidation of statements is gained through questions and comparisons, and international competition and criticism can on occasion be more than diverting.

William A. Campbell, M.D.

Convulsive Disorders of Children: By Dora Hsi-Chih Chao, M.D., Ralph Druckman, M.D., and Peter Kellaway, A.M., Ph.D. Phila., W. B. Saunders Company, 1958. 151 p. Price: $6.00.

For ten years, a pediatric seizure unit with the unlikely name of the Blue Bird Circle Children's Clinic has operated as part of the Baylor University College of Medicine in Houston, Texas. Supervision and direction of the affairs of this clinic have been undertaken largely by the authors of this book, namely, a pediatrician, a neurologist, and a physiologist. The book itself is a revised version of a manual on convulsive disorders which the authors originally prepared for the use of residents in the Blue Bird Circle Children's Clinic. It is an attempt to provide a concise and simple review of diagnosis, treatment, and management of the convulsive disorders and is based primarily on the data collected and developed in the clinic since its establishment in 1949. The emphasis is clinical but sufficient physiology and pathology are given to afford the reader an understanding of the fundamental mechanism involved.

An attempt is made to drop the terms "grand mal" and "petit mal" because the latter particularly is a term used with many different meanings and its general usefulness has become limited. Consequently, classification of the convulsive disorders is given as follows: (1) idiopathic (or genetic) epilepsy; (2) symptomatic epilepsy; and (3) conditions related to or confused with epilepsy (such as benign febrile convulsions and breath holding).

Idiopathic epilepsy is further divided into (1) lapse or absence attacks; (2) myoclonic jerks; (3) akinetic attacks; (4) automatisms; and (5) generalized convulsions.

Symptomatic seizures are defined as those resulting from a lesion of the brain, whereas conditions which are related to or which may be confused with epilepsy are those disorders in which there are convulsive attacks but in which there is a necessary and invariable extra-cerebral excessory factor. Such conditions include convulsions

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HIGHLIGHTS FROM THE A.M.A. COUNCIL ON DRUGS

REPORT ON TRIAMCINOLONE

J.A.M.A. 169:257 (January 17) 1959.

"It [triamcinolone] has an anti-inflammatory potency greater than an equal amount of prednisolone; i.e., comparable suppressive effects may usually be achieved with lower doses of triamcinolone than with prednisolone."

"Triamcinolone lacks the sodium-retaining and edema-producing effects of most other glucocorticoids. During the first several days of administration, it may cause a loss of sodium from the body; an initial mild diuretic action is frequently observed, whether the patient is frankly edematous or not. This is in contrast to the definite sodium-retaining and fluid-retaining properties of cortisone and hydrocortisone and to a much lesser extent with prednisone and prednisolone."

"Except in exceedingly large doses, triamcinolone apparently has no consistent effect on potassium excretion. Hence, neither sodium restriction nor potassium supplementation is ordinarily required during therapy with this agent."

"As with other glucocorticoids, the long-term administration of triamcinolone results in definite catabolic effects, as indicated by impairment of carbohydrate utilization and negative protein and calcium balance. This catabolic effect, coupled with a lack of appetite stimulation which is apparently peculiar to triamcinolone, may produce weight loss that might be undesirable in some patients treated for long periods of time."

"...the voracious appetite, with weight gain and euphoria, characteristic of other steroids, is not seen with administration of triamcinolone."

"Triamcinolone has been used for the management of a wide variety of clinical conditions usually considered amenable to systemic steroid therapy. These have included rheumatoid arthritis and other collagen diseases, allergic and dermatological disorders, certain leukemias and malignant lymphomas, the nephrotic syndrome, pulmonary emphysema and fibrosis, acute bursitis, rheumatic fever, and certain blood dyscrasias. Although clinical experience with the drug in some of the foregoing conditions is not extensive, the many similarities in action between triamcinolone and other potent glucocorticoids would indicate a usefulness for triamcinolone akin to that of other agents of this class."

"There is some evidence that triamcinolone is more effective at a smaller dosage than are other steroids in controlling both the skin and joint lesions in psoriasis, whether or not complicated by arthropathy."

"Triamcinolone appears to compare favorably with other steroids for use in those situations in which edema and sodium retention have been complicating problems."

"It [triamcinolone] may also be the steroid of choice for patients in whom psychic stimulation, euphoria, voracious appetite, and weight gain should be avoided."

"...the drug [triamcinolone] does produce the other side effects and untoward reactions common to the glucocorticoids. At therapeutically equivalent doses, the frequency and severity of clinical manifestations of hyperadrenalism — rounding of the face, fat deposition, and hirsutism — are essentially the same. Likewise, there is little indication that the relative incidence of osteoporosis is materially decreased after the long-term use of the drug."

"Triamcinolone apparently does not cause the euphoria sometimes seen with other steroids, and the occurrence of mental depressions is uncommon."

"Current evidence suggests that the drug [triamcinolone] may not produce as high an incidence of peptic ulcer as do other steroids."

"Cutaneous erythema seems to be a side effect peculiar to triamcinolone."

"The usual contraindications and precautions of glucocorticoid therapy should be followed in the use of triamcinolone, keeping in mind that prolonged therapy with this drug will suppress the function of the patient's own adrenals by interfering with the pituitary-adrenal axis."

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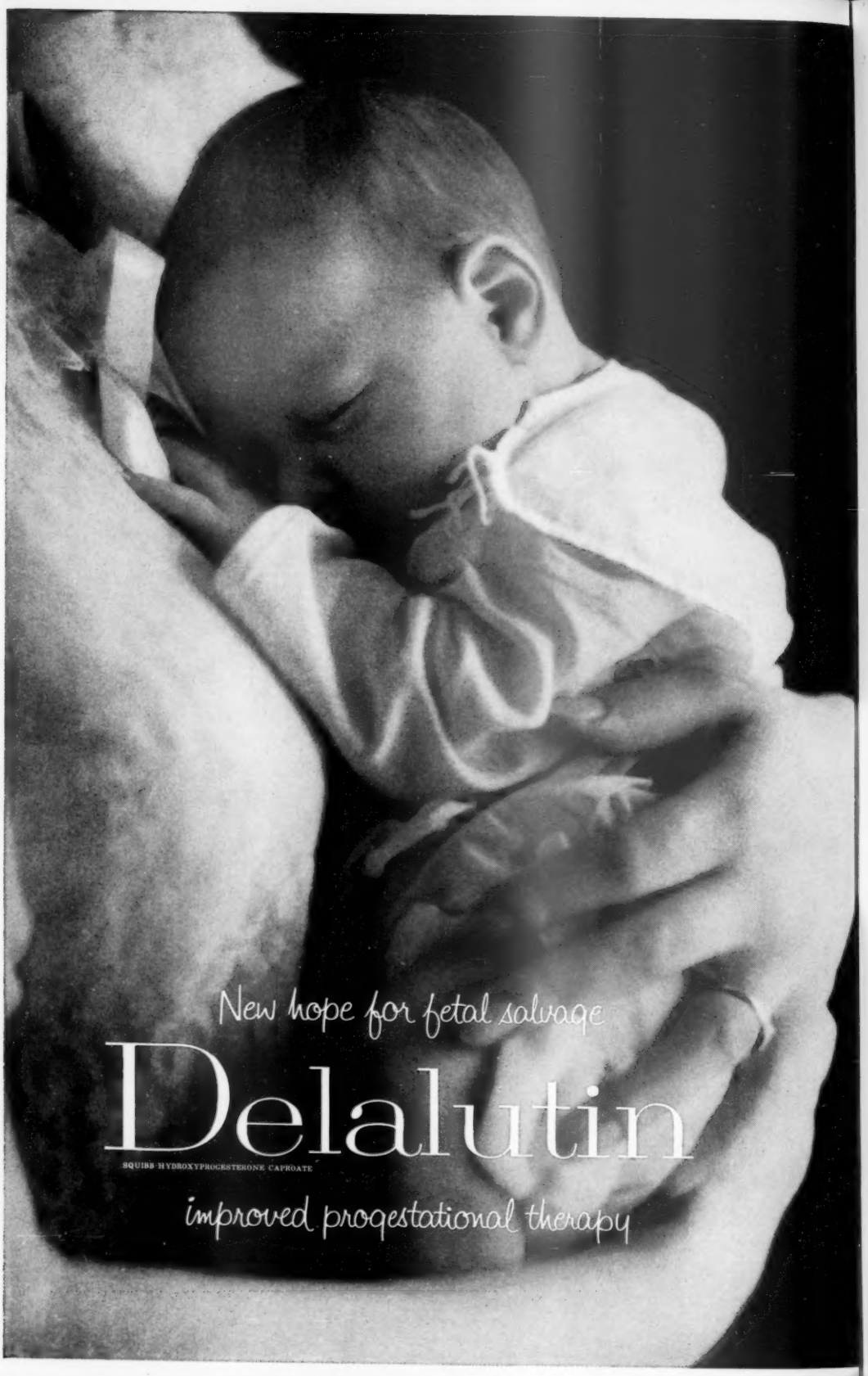
New hope for fetal salvage
Delalutin
SQUIBB HYDROXYPROGESTERONE CAPROATE
improved progestational therapy

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.[1] Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy
64% of 42 pregnancies were salvaged by progesterone
83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.
108 (76%) of 142 babies of this birth weight survived without progestational therapy.
16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.
A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and Dosage: Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

The Colorado State Medical Society

Rocky Mountain Medical Conference, September 8-11, 1959
Denver

President: John I. Zarit (Chairman of the Board), Denver.
President-elect: John L. McDonald, Colorado Springs.
Vice President: Robert P. Harvey (Vice Chairman of the Board), Denver.
Treasurer: William C. Service, Colorado Springs, 1959.

Constitutional Secretary: Harry C. Hughes, Denver, 1960.
Additional Trustees: Bernard T. Daniels, Denver, 1959; Carl W. Swartz, Pueblo, 1960; Fred R. Harper, Denver, 1961; Walter M. Boyd, Greeley, 1961.

Delegates to the American Medical Association: Kenneth C. Sawyer, Denver, 1960; (Alternate, Irvin E. Hendryson, Denver, 1960); E. H. Munro, Grand Junction, 1960; (Alaternate, Harlan E. McClure, Lamar, 1959).

Executive Secretary: Mr. Harvey T. Sethman, 835 Republic Building, Denver 2, Colorado; Telephone AComa 2-0547.

Montana Medical Association

Annual Meeting, September 17-19, 1959
Butte

President: Herbert T. Caraway, Billings.
President-elect: Leonard W. Brewer, Missoula.
Vice President: Raymond F. Peterson, Butte.
Acting Secretary-Treasurer: W. E. Harris, Livingston.

Assistant Secretary-Treasurer: W. E. Harris, Livingston.
Executive Committee: Herbert T. Caraway, Billings; Leonard W. Brewer, Missoula; Raymond F. Peterson, Butte; W. E. Harris, Livingston; John A. Layne, Great Falls; Edward S. Murphy, Missoula.

Delegate to American Medical Association: Paul J. Gans, Lewiston; alternate, S. C. Pratt, Miles City.

Executive Secretary Mr. L. R. Hegland, P.O. Box 1692, Telephone 9-2585, Billings.

Nevada State Medical Association

Annual Meeting, August 19-22, 1959
Reno

President: Roland Stahr, Reno.
President-elect: Ernest W. Mack, Reno.
Secretary-Treasurer: William A. O'Brien, III, Reno.

Delegate to American Medical Association: Wesley W. Hall, Reno; alternate: Earl N. Hillstrom, Reno.

Executive Committee: Roland Stahr, Reno; Ernest W. Mack, Reno; William A. O'Brien, III, Reno; Wesley W. Hall, Reno; Earl N. Hillstrom, Reno; Stanley L. Hardy, Las Vegas; Thomas S. White, Boulder City; John M. Read, Elko; John M. Moore, East Ely; William M. Tappan, Reno.

Executive Secretary: Mr. Nelson B. Neff, P. O. Box 188, Reno; telephone FA. 3-6788.

New Mexico Medical Society

President: James C. Sedgwick, Las Cruces.
President-elect: Lewis M. Overton, Albuquerque.
Vice President: Allen L. Haynes, Clovis.
Secretary-Treasurer: Omar Legant, Albuquerque.

Councilors: Junius A. Evans, Las Vegas, 1959; Aaron E. Margulis, Santa Fe, 1959; Wendell Peacock, Farmington, 1960; George Prothro, Clovis, 1960; Gerald Slusser, Artesia, 1960; W. J. Hossley, Deming, 1961; Guy Rader, Albuquerque, 1961.

Delegate to American Medical Association: Earl L. Malone, Roswell, 1960; Alternate: Samuel R. Ziegler, Espanola, 1960.

Executive Secretary: Mr. Ralph R. Marshall, 220 First National Bank Building, Albuquerque, telephone CH 2-2102.

The Utah State Medical Association

Annual Session, September 15-18, 1959
Salt Lake City

President: U. R. Bryner, Salt Lake City.
President-elect: I. Bruce McQuarrie, Ogden.
Secretary: J. Poulson Hunter, Salt Lake City.
Treasurer: Robert M. Dalrymple, Salt Lake City.

Councilors: Box Elder, 1960, D. L. Bunderson, Brigham City; Cache Valley, 1960, C. J. Daines, Logan; Carbon County, 1960, A. R. Demman, Helper; Central Utah, 1959, Stanford Rees, Gunnison; Salt Lake, 1960, Richard W. Sonntag, Salt Lake City; Southern Utah, 1960, James S. Prestwich, Cedar City; Uintah Basin, 1960, R. Bruce Christian, Vernal; Weber County, 1961, Wendell J. Thompson, Ogden; Utah, 1959, R. E. Jorgenson, Provo.

Executive Committee: U. R. Bryner, Salt Lake City, Chairman; Reed W. Farnsworth, Cedar City; I. Bruce McQuarrie, Ogden; J. Poulson Hunter, Salt Lake City; Robert M. Dalrymple, Salt Lake City.
Delegate to American Medical Association, 1957-1959: Kenneth B. Castleton, Salt Lake City; Alternate, Drew Petersen, Ogden.
Executive Secretary: Mr. Harold Bowman, Salt Lake City.

The Wyoming State Medical Society

Annual Session, June 11-14, 1959
Jackson Lake Lodge

President: L. Harmon Wilmoth, Lander.
President-elect: Benjamin Gitlitz, Thermopolis.
Vice President: Francis A. Barrett, Cheyenne.
Secretary: S. J. Giovale, Cheyenne.
Treasurer: C. D. Anton, Sheridan.

Councilors: Albany County, B. J. Sullivan, Laramie; Carbon County, Guy Halsey, Rawlins; Converse County, Roman Zwalsh, Glenrock; Fremont County, Bernard Stack, Riverton; Goshen County, Joseph Volk, Torrington; Laramie County, S. J. Giovale, Cheyenne; Natrona County, Frederick Haigler, Casper; Sheridan County, Jay Blumenstock, Sheridan; Teton County, Robert Knapp, Pinedale; Uinta County, Joseph Whalen, Evanston; Northeastern Wyoming, Virgil L. Thorpe, Newcastle; Northwestern Wyoming, John H. Froyd, Worland.

Delegate to A.M.A.: A. T. Sudman, Green River, 1960; Alternate, B. J. Sullivan, Laramie, 1960.

Executive Secretary: Mr. Arthur R. Abbey, Cheyenne.

The book corner cont. from 125

due to excessive fever, hypoglycemia, toxins, and anoxia.

The authors then proceed to enlarge on each variety of seizure defined in the classification and to list the methods of investigation and the treatment of each type. There is a chapter on electroencephalography and a well written chapter on seizure management. A drug table is placed at the end of the book, and the drugs used are most of those now regarded as old standbys and valuable recent additions in the field of convulsion pharmacology.

This is a valuable book for pediatricians and neurologists alike, because of its effort to simplify a complex field and because of the reasonable method of approach. Just as an artist becomes accustomed to a palette of several well established pigments, so the pediatrician who uses this book will learn more about seizures as he sees them in his practice than if he attempted to correlate the information provided by numerous books in the field.

This reviewer found no disadvantages or erroneous statements and regards this volume as a valuable addition to the standard sections on epilepsy in the accepted pediatric texts.

S. E. Wheelock, M.D.

Practical Dermatology: By George M. Lewis, M.D., Professor of Clinical Medicine (Dermatology), Cornell University Medical College. Second Edition. Phila., W. B. Saunders Company, 1959. 363 p. Price: $8.50.

This book retains all the features of the first edition published seven years ago. Alterations in the text have been made to bring it up-to-date, and numerous new illustrations have been added. The symptoms, differential diagnosis, etiology, pathology, and treatment of each skin ailment is presented as succinctly as possible. A chapter on basic sciences in dermatology has been added. The black and white illustrations are of exceptionally high standard, and well selected. The photographs are excellent. Many of the diseases depicted can be recognized without the help of the identifying caption. The author makes it very clear in the preface that it is not his intention to write a treatise on dermatology, but a practical book for the medical student and medical practitioner. He has succeeded in this objective.

Egbert J. Henschel, M.D.

Review of Physiological Chemistry: By Harold A. Harper, Ph.D. Sixth edition. Los Altos, Calif., Lange Medical Publications, 1957. 376 p. Price: $4.50.

This review of the chemistry of the bodily functions is notable for its clarity and its pertinence to clinical medicine. The material is carefully organized and the presentation is concise yet the text is sufficient to present significant detail. The emphasis is on currently accepted nonspeculative concepts of biochemistry. The sections on general and physical chemistry present in previous editions have been omitted so that new chapters dealing with the subject of metabolism could be added.

This book is useful as a review for state board and other examinations. As a supplementary guide for students it gives an over-all view of the subject which is difficult to find in the necessarily longer and more detailed standard texts. Finally, it is admirably suited for those clinicians who wish to keep up to date in this basic science.

David R. Rice, M.D.

Tracheotomy cont. from 72

REFERENCES

[1]Blair, N. J.: Canadian Medical Journal, 72 (10), 15 May 55, p. 766-8.

[2]Schmid-Schmidsfelden: Wiener Klinische Wochenschrift, 66 (42), 14 Jan. 55, p. 39-41.

[3]Fontaine, et al.: Revue Neurologique, 89:6, 1953, p. 550-2.

[4]Colvin, et al.: Surgery, Gynecology and Obstetrics, 96:3, Mar. 53, p. 338-42.

[5]O'Brien, et al.: American Medical Association Journal, vol. 156, Sept. 54, p. 27-31.

[6]Echols, et al.: Surgery, 1950, 28, p. 801-11.

[7]Davis, et al.: American Medical Association Journal, 1954, p. 1156-9.

[8]Robin, J. L.: Revue do Laryngologie, 76 (3-4), Mar.-Apr. 55, p. 187-9.

[9]Cookson, et al.: Disease of the Chest, 1952, 22:245-260.

[10]Cookson, et al.: Journal of the International College of Surgeons, 1952, 18, p. 685-694.

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SPACE available in new air conditioned Medical Building in Colorado Springs, Colorado. Location excellent for Generalists, Specialists, or Dentists. Ample off street parking. Near new hospital and adjacent to a large shopping center. Will partition to suit. E. H. Vincent, M.D., Suite No. 1, Madison Medical Building, 2121 North Weber Street, Colorado Springs, Colorado. Phone MElrose 2-9386. 4 TF.

GENERAL SURGEON, Certified, 33, wants to locate in southern half of Rocky Mountain area. Write Box 4-13, 835 Republic Building, Denver 2, Colorado.

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FOR RENT: Physicians' offices available in new Medical Center in busy Northeast Colorado Springs. Possibilities unlimited for Pediatrician, Obstetrician, Internist and Endocrinologist. Please investigate. Will install $2,000.00 free partitioning, plumbing, etc., to suit. Air conditioned. 100 car parking. E. Nirk, 2621 Holiday Lane, Colorado Springs. ME. 4-8978. 4-3

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NEVADA COMMUNITIES seeking physicians include Wells, Carlin, Austin, Beatty, Ploche, and Hawthorne. Write Mr. Nelson B. Neff, Executive Secretary, Nevada State Medical Association, P. O. Box 188, Reno, Nevada, for further information regarding these opportunities. 5tf

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